IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

CARISSA PERONIS, et al.,
Plaintiffs
vs.
UNITED STATES OF AMERICA, et al.,
Defendants.

Civil Action No. 16-1389

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Transcript from proceedings on September 4, 2019, United States District Court, Pittsburgh, PA, before Judge Nora Barry Fischer.

APPEARANCES:

For the Plaintiffs:	Harry S. Cohen & Associates, P.C. Douglas L. Price, Esquire Two Chatham Center Suite 985 Pittsburgh, Pennsylvania 15219
For the Defendant USA:	U.S. Attorney's Office Michael Colville, Esquire Philip P. O'Connor, Jr., Esquire U.S. Courthouse 700 Grant Street Pittsburgh, Pennsylvania 15219
For the Hospital Defendants and Dr. Jones	Weber Gallagher Simpson Stapleton Fires & Newby Paula A. Koczan, Esquire 603 Stanwix Street Suite 1450 Pittsburgh, Pennsylvania 15222
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THE COURT: Good morning, everyone. We left off last evening with proceedings in this matter styled Carissa Peronis versus United States of America et al. with the argument vis-a-vis Dr. Jones. The court has made its ruling. That's confirmed in writing and it should be on the docket shortly.

In addition, the court had suggested to hospital counsel that she take a look at the proposed instructions. We received an e-mail last night pointing out a factual error in regard to the employer of Dr. Jones. We had previously seen that vis-a-vis the verdict slip and corrected it. We apologize that it was not done vis-a-vis the instructions. Ms. Starr should have made that correction by this time.

Now, in addition, Ms. Koczan points out that she has another issue vis-a-vis damages. Do you want to outline your position for the court?

MS. KOCZAN: Your Honor, it's really with regard to the irrelevant considerations charge, and what my issue with that is is that that charge is not factually accurate.

THE COURT: As you know, we prepared it in advance based on everything that was submitted to the court. I didn't know what you were or weren't going to put on in terms of this case at that time. That's why it's called a discussion draft, so I need you to reference page and line what you want deleted, and then we're going to hear from the attorney for the plaintiffs as to what his position is, whether these

matters are or aren't irrelevant.

MS. KOCZAN: Your Honor, what I'm objecting to is, and I perhaps should have been clearer. I'm objecting to the entire charge because the charge basically says that there is really no impact on the physician, you know, financially or otherwise. I know that that is a charge that is routinely given. It's an approved charge, but I need to take an exception to it for the record, because factually, it is not correct. There are many ramifications to physicians as a result of medical negligence cases, verdicts, et cetera, so factually, the charge is not correct and I just --

THE COURT: But to that end, we have had no evidence. We have had no evidence about the database. We have had no evidence about the insurance policy, if any. We have had no evidence about self-insured retention. We have had no evidence vis-a-vis reputation, although reading depositions, apparently there was some indication that family members and/or friends had concerns, let's say, about Dr. Dumpe and/or Dr. Lauer.

The court is well aware by judicial notice that Dr. Dumpe's partner, Dr. Lauer, was previously sued for a shoulder dystocia which the government chose to settle. You went to verdict. The hospital won, so to that end, you know, there's no evidence in the record unless you want to put it on.

MS. KOCZAN: The only reason I'm making -- made the comment is I just would like an exception to that. I'm not objecting to the court giving the instruction, because I know it is one that is commonly given, but I do need to take an exception to it. That was all I was pointing out.

THE COURT: Mr. Price, what's your view on this?

MR. PRICE: I believe it's a proper charge.

THE COURT: It's a standard charge, and so far, the Pennsylvania Supreme Court has not thought to disabuse trial courts of using that charge.

MS. KOCZAN: Your Honor, I wholeheartedly agree. I'm just pointing it out because, as I indicated, it is not factually correct, so I need to take exception, but I'm not opposing you giving the charge. It's just that I need to put an exception on the record, because it's not factually correct.

THE COURT: I guess your position is noted. Mr. Price yesterday was very concerned about the court's questioning about the bacterial vaginosis that was described and prescribed in the prenatal care of the plaintiff, and I understand that he's talked to Mr. Colville, and he and Mr. Colville are agreeing that that particular issue should not be addressed by this jury, and I thought you were going to give me some language. Did you send an e-mail to Ms. Starr on that front?

MR. PRICE: I apologize, Your Honor. I have a draft.

THE COURT: If you have a draft, what I want you to do at a break is talk to Mr. Colville and to Ms. Koczan and if you all agree on it, then we'll insert it in the appropriate place as to that charge.

Now, at this point, is there anything else anybody wants to bring to my attention vis-a-vis the charge? At least twice Mr. Price said he had no issues with the charge. Ms. Koczan, nothing further?

MS. KOCZAN: No, other than what I've included in that e-mail, I'm fine.

THE COURT: Mr. Colville takes no position. So as I told Ms. Starr last night when we were working on this, I'm going to read through the charge again, and based on what I'm doing vis-a-vis the Rule 50 on the corporate negligence side, you know, I may make some additional changes there.

Now, outside of that, anything else legal or administrative you want to bring to my attention before we hear these next two experts?

MR. PRICE: Nothing.

MS. KOCZAN: Nothing.

MR. COLVILLE: No, Your Honor.

THE COURT: Mr. Galovich, is everybody here?

THE CLERK: No, ma'am, not yet.

THE COURT: We had one gal who was here bright and

early reading a book every morning, so we still need a juror or two.

MS. KOCZAN: Can I go out and see if my experts are here?

THE COURT: That's a good idea.

MS. KOCZAN: I don't know if they are physically here yet, but they should be.

THE COURT: Who's going to be number one? Coffin or Ringer.

MS. KOCZAN: I'm going to put Dr. Coffin on first. She has an earlier flight.

THE COURT: I'll do my limiting charge vis-a-vis her when she gets in here.

MS. KOCZAN: As soon as we get done with her, Dr. Ringer I believe is out there and we'll put him on immediately afterwards.

THE COURT: And then you'll rest.

MS. KOCZAN: And then I will rest, correct.

THE COURT: Mr. Colville, you need to still rest at some point.

MR. COLVILLE: Yes, Your Honor.

THE COURT: And have you decided, Mr. Price, if you are going to do any rebuttal or not?

MR. PRICE: No rebuttal.

THE COURT: Okay. So Ms. Koczan, do you want to

check the hallways for your witness?

MS. KOCZAN: Yes, I'm going to look to see if they are out there.

MR. PRICE: Your Honor, may we run to the restroom real quick?

THE COURT: Yes, I think now would be an appropriate time. As soon as the jurors are all assembled, we'll start.

(Recess taken.)

(Jury present.)

THE COURT: Morning, ladies and gentlemen of the jury. I understand that Ms. Koczan's witnesses are both here and ready to testify. She is first going to be calling Dr. Susan Coffin.

Dr. Coffin, if you'll approach Mr. Galovich, my deputy, to be sworn.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Susan Coffin, C-O-F-F-I-N.

(Witness sworn.)

THE COURT: Thank you, Doctor. When you get over to the steps, watch your step. It's a little uneven. Once you are situated, please arrange the microphone so you are speaking into it. It moves towards you. It can also go up and down.

In addition, in case you need it, there's water

there. You'll notice there's a monitor next to you. You may be asked to look at that monitor from time to time.

Now, ladies and gentlemen of the jury, as I just told you a moment ago, you are going to be hearing the testimony containing opinions from Dr. Susan Coffin, a physician who will offer her opinions because of her knowledge, skill, experience, training or education in the field of pediatric neonatal care and infectious disease and the reason for her opinions.

In weighing her opinion testimony, you may consider all of her qualifications, the reasons for her opinions, the reliability of the information that supports those opinions, as well as any other factors I'll discuss with you in my final instructions when I instruct you on how to weigh the testimony of witnesses.

The opinion of Dr. Coffin should receive whatever weight and credit, if any, you think appropriate given all the other evidence in this case. You may disregard the opinions entirely if you decide that Dr. Coffin's opinions are not based on sufficient knowledge, skill, experience, training or education. You can also disregard her opinions if you conclude that the reasons given in support are not sound, if you conclude that the opinions are not supported by the facts shown by the evidence or if you think the opinions are outweighed by other evidence in this case.

Once again, in deciding whether to accept or rely upon these opinions, you can consider any bias Dr. Coffin may have, including any bias that may arise from the fact that Dr. Coffin has been or will be paid for reviewing this case and testifying in this case.

In addition, you may hear evidence that Dr. Coffin testifies regularly and makes a portion of her income from testifying in court. You can also consider that. With that, Ms. Koczan, you may proceed.

MS. KOCZAN: Thank you, Your Honor.

SUSAN COFFIN, M.D., a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KOCZAN:

Q. Good morning, Doctor. Can you please introduce yourself to the jury?

A. My name is Dr. Susan Coffin. I'm a pediatric infectious disease specialist, and I work at Children's Hospital of Philadelphia.

Q. And is Children's Hospital of Philadelphia still one of either the top or one of the top children's hospitals --

A. One of the top. Not the top.

Q. -- in the country. What is your current academic position?

A. I'm a professor of pediatrics at the University of

Pennsylvania School of Medicine.

Q. And I assume because you practice in that area, you live in Philadelphia?

A. I live in Philadelphia proper, yes.

Q. Can you tell the jury about your education? Start with undergraduate and bring us up through medical school.

A. Sure. I went to Williams College in western Massachusetts for my undergrad. I then went straight to medical school at the University of Vermont. I did my pediatric residency training for a few years in Baltimore at Johns Hopkins Hospital, and then moved up to Philadelphia where I started an infectious disease fellowship, and once that was completed, I began working at that hospital as a faculty member in pediatric infectious diseases.

Q. We've heard from another pediatric infectious disease expert, but I would like you to very briefly explain to the jury what do you do as a pediatric infectious disease physician?

A. The practice of pediatric infectious diseases is a bit different than what you might think of as the general practice of pediatrics. General pediatricians are great infectious disease doctors. That's most of the reasons why people go to see their pediatrician with their child if it's not for a checkup.

So a pediatric infectious disease doctor like myself

spends most of their time in a hospital taking care of children with severe enough infections that they require hospitalization, so the bulk of my work is seeing children who are hospitalized with infections. Not outpatients.

Q. And in addition to your medical degree, I also see from looking at your curriculum vitae, you have a master's in public health. Can you explain to the jury what that is and why you have that degree?

A. Sure. A master's in public health is a one or two year course that people often take after they have completed some part of their health or medical training, whether it's nursing or physicians, and it provides an interesting complement to the clinical training, in that it gives you a perspective beyond just an individual patient but at a population level, and I've always been interested in population health and such.

Q. Are you board certified?

A. I am.

Q. What areas of medicine are you board certified in?

A. Pediatric infectious diseases.

Q. And can you tell the jury a little bit about your practice since you completed both your medical training, internship, residency and the master's in public health?

A. Currently, I spend my time split between a couple of different activities. I take care of patients who are hospitalized at Children's Hospital of Philadelphia. In that

context, I'm often teaching medical students, residents and fellows, which are people getting prepared to be independent pediatric infectious disease doctors.

I also do research, clinical research and help oversee some of the programs of our division, such as the training program for the fellows and some of the administrative functions of our division.

Q. In terms of your clinical practice, actually seeing and treating patients, how frequently do you do that? Is that an everyday thing?

A. It constitutes about 20 percent of my time, somewhere between six, eight, ten weeks a year, depending on what the year looks like from the rest of the group of doctors I work with.

Q. And you described teaching responsibilities and who you teach. What is it that you are teaching them? Is it limited to infectious disease type things?

A. Yes. Yes. It's virtually all infectious diseases, other than career mentoring that I do for junior faculty members, coaching them how to build a career in medical school.

Q. You talked about research. What sort of research do you engage in?

A. My research now is focused on clinical research in disease prevention largely, prevention of infectious diseases, and my specific area of interest is preventing hospital or health

care associated infections and addressing antibiotic resistance.

Q. Doctor, in looking at your CV, I also see that you are an epidemiologist, and in fact, I think you are the associate hospital epidemiologist at CHOP; is that correct?

A. Yes.

Q. Can you tell the jury what that position is and what you do in that position?

A. Sure. So if you have been admitted to a hospital, you may be aware that there's a function going on behind the scenes at the hospital to try and keep a patient safe from acquiring an infection while they are in the hospital for some other reason. You know, if you go in needing a broken bone to be fixed, you don't want to come out with an infection.

So the function of a hospital epidemiologist is to provide the work that ensures everybody is cleaning their hands, that the instruments used in surgery are sterile and things like that.

Q. I also note from your curriculum vitae that you are the clinical director of infectious diseases at Children's Hospital of Philadelphia. What responsibilities do you have in that role?

A. Largely it's addressing all of the design and delivery of our clinical care at our division. Our hospital is now quite large, and so we actually have three different groups of

pediatric infectious disease doctors working simultaneously, and trying to keep the ebb and flow of all of the work across those groups is one of my major functions in that role.

Q. I also see that you are the associate fellowship program director at CHOP. What responsibilities do you have in that job?

A. To train in infectious diseases, there's actually some fairly strict criteria that you have to meet in order to be established to be competent and work independently, so it's my role overseeing the formal education, like classroom-type education and lectures that our trainees get, as well as their ability to deliver good care and think in a clinical setting as we go around the hospital seeing patients.

Q. Finally, I also see that you are the associate chief of the division of infectious diseases at CHOP. What responsibilities do you have in that position?

A. Again, these are positions that get wrapped up together. All of these are part of, I think, being the associate chief.

In addition, there are issues surrounding the support of the nurses that we work with in our infectious disease practice and things to do with making sure that the junior faculty who are working to get research funding are succeeding and just coaching the entire group.

Q. You've mentioned being on staff at Children's Hospital of Philadelphia. Are you on staff at any other hospitals?

A. I do have staff privileges at the hospital at the University of Pennsylvania. The work of our neonatology group at Children's Hospital of Philadelphia is also conducted at the hospital at University of Pennsylvania, so I have privileges there to go and see a baby in their NICU, their neonatal intensive care unit.

Q. Are you a member of various professional societies and organizations in the field of infectious disease?

A. I am.

Q. Can you tell the jury about just one or two of them?

A. I am a member of the Pediatric Infectious Disease Society of America -- these don't have very creative titles -- the Infectious Disease Society of America and the Society For Health Care Epidemiology of America, so all groups of similarly-minded physicians, nurses, other folks.

Q. During the course of your career, have you been the recipient of various honors and awards?

A. I have won several awards.

Q. Again, if you can tell the jury about one or two of them?

A. I guess the award I'm most proud of is an award I won for monitoring trainees from the Society of Health Care Epidemiology, so that was given to me for supporting their development.

Q. We talked before about researching, and you've indicated that you do conduct research, and I believe you've already

told us the types of things that you research; is that correct?
A. Right.
Q. Is that something you have been doing throughout the course of your career?
A. It has. I started doing research as a fellow myself, so for 20 plus years.
Q. Do you also lecture both nationally and internationally?
A. I do.
Q. And again, without going into great detail, if you would tell the jury about a couple of the lectures or presentations that you've given that may be pertinent to what we're going to be talking about here today?
A. One area that I've been recently doing a moderate amount of work in is neonatal sepsis, so infections in neonates, particularly in resource limited countries, so I've done a bit of work in Sub-Saharan Africa, and that's been a good number of the recent talks I've given is focused on some of the work we've done in that setting.
Q. Do you also write, author articles, books, book chapters, that type of thing, and again, could you tell the jury just generally how many of those publications have you authored, how many book chapters, and are any of them pertinent to what we are talking about today?
A. So I don't know the numbers. I know it's over 100

articles in what I refer to as peer reviewed journals, so those are journals where other researchers read and make sure it's accepted for publication.

I've written ten plus book chapters, several focused on neonatal infections and some review articles which are kind of like short book chapters often published in journals.

Q. Over the course of your career, how many patients have you seen and treated with just broadly the term neonatal sepsis?

A. Many. I don't know what the number is. I would say that each time I'm in the hospital taking care of patients ten times a year, there are a couple that I take care of over the course of that week, and so I think it would be, you know, ten, 20 a year children, babies that have infections like this.

Q. What about babies with E. coli sepsis like we have been talking about here in this case? How frequently do you see and treat those types of patients?

A. Specifically with E. coli, not as frequently as all cases of neonatal sepsis. E. coli is not the most common cause of neonatal sepsis, but it is amongst the more common causes.

Q. And are you ever asked to see babies who have had meconium noted either during labor or delivery?

A. I am.

Q. And under what circumstances might you be asked to see those babies?

A. Well, typically, meconium is part of their history. It's not a driver of the infection that I'm usually asked to comment on, so it becomes part of the story, the background story of the baby. It's not typically front and center in my work as an infectious disease doctor.

Q. And that was my next question. Now, does the presence of meconium or even meconium aspiration necessarily lead to the development of an infection for which you would be consulted?

A. No. You may have heard this before, but meconium is sterile, and so even if it is aspirated into the lungs, it doesn't bring germs or bacteria with it.

Q. And, Doctor, over the course of your career, have you been asked to review medical-legal matters like we are here today about?

A. Yes, I have.

Q. How long have you been doing that?

A. I think I probably did my first review maybe 15 years ago.

Q. And how frequently do you get asked to do that?

A. Currently, not infrequently. Once a month.

Q. And can you give us some idea of how many of the cases that you get asked to review are for plaintiffs, people bringing the lawsuits, versus the defendant, the people being sued?

A. Sure. I guess maybe I should clarify a little. I'm asked to do it maybe once a month. I typically only do two to three

a year. Trying to not overwhelm all of my other work.

I have done some reviews for plaintiffs. I don't think it's the majority of my work that I've done for medical-legal.

MS. KOCZAN: At this stage, I would offer Dr. Coffin as an expert in pediatric infectious diseases.

THE COURT: Okay. Mr. Colville, any cross?

MR. COLVILLE: No.

THE COURT: Mr. Price?

MR. PRICE: I'll reserve.

THE COURT: So given what we've heard, the court now accepts Dr. Coffin as an expert and specialist in the field of pediatric infectious disease. You may proceed, Ms. Koczan.

MS. KOCZAN: Thank you.

BY MS. KOCZAN:

Q. Doctor, were you asked by my office to review certain records and materials in this case?

A. I was.

Q. And did you review the following? I'm just going to give you the list rather than have you try to recall. The complaint that started this lawsuit?

A. Yes.

Q. Dr. Dumpe's office records for Ms. Peronis?

A. Yes.

Q. Ms. Peronis's Heritage Valley records for labor and delivery?

A. Yes.
Q. Kendall Peronis's Heritage Valley records? The LifeFlight records --
A. Yes.
Q. -- from West Penn Hospital. Have you had a chance to look at the autopsy report as well?
A. Yes.
Q. The depositions of -- there's a list: Carissa Peronis, Matthew Fritzius, Jamie McCrory, Katherine Gantz, Barbara Hackney, Judith Ash, Maria Hendershot, Dr. Heiple, Dr. Jones, Dr. Dumpe, Dr. Min. Have you seen all of that?
A. I believe I have. I haven't committed to memory the list of names.
Q. Have you also had an opportunity to review the plaintiffs' experts' reports, and that being the report of Dr. Zamore, the report of Dr. Shore and the report of Dr. Karotkin?
A. Yes, I have.
Q. Now, based upon your review of the medical records, depositions in this case, can you tell the jury what this case is about from a pediatric infectious disease perspective?
A. From my perspective, the case really highlights just how rapid and devastating a bacterial infection can be in a newborn, and that particularly at the moment of birth, how challenging it is to differentiate signs of infection from the normal physiologic changes that have to happen to have a baby

flip their functioning from being attached to the mom's placenta to being out in the world.

Q. And based upon your review of the medical records and other materials, did you, first and foremost, form an opinion as to what caused Kendall Peronis' death?

A. I think she had an overwhelming infection with E. coli, escherichia coli bacteria.

Q. Did you form an opinion as to whether meconium had any causative effect on leading to her death?

A. From my understanding, while the meconium was present, there were many, many indications that overwhelming infection is what resulted in her deterioration and death.

Q. Did you also form an opinion as to when this E. coli infection started?

A. I do think that this is a situation in which Kendall actually acquired the infection before she was delivered, before she was born, and knowing exactly when before she was born, I can't hazard a guess, but I think she was born with the bacteria in her lungs.

Q. Why do you believe that she was born with the bacteria in her lungs?

A. In thinking about the very, very short timeline between her birth and when she became so obviously critically ill, there just isn't time to introduce a couple of bacteria, have them grow to such a large amount that they would trigger this

kind of response where her lungs couldn't oxygenate, the rest of her body, the blood pressure couldn't stay up where it needed to.

Q. Did you also form an opinion as to when, in Kendall's course, the infection first began manifesting itself? In other words, when she first developed symptoms and when?

A. You know, I think the first symptoms, in reviewing the record, that I saw with the descriptions of her having what's called nasal flaring and intercostal retraction, signs that she was working harder to breathe, and then when she was checked in the nursery shortly thereafter, she is found to have quite low concentrations of oxygen in her blood.

Q. And do you also have an opinion as to whether earlier administration of antibiotics would have reversed this process, this overwhelming infection, or made any difference whatsoever in the outcome in this case?

A. Sadly, I don't think they would have. The tempo of this -- very, very rapid tempo carries with it a sense of inevitability that the bacteria had the upper hand and that the immune response that they were triggering was causing extensive inflammation and damage.

Q. I want to talk a little bit, before we talk about Kendall and what happened to her, about infections in general, since that's your area.

How do infections in neonates develop? What would the

mechanism be for the development of infections?
A. Probably the most common way for a baby to develop an infection is to be exposed to a bacteria in the process of being born or once out in the outside world.
As probably most people are aware, a baby is built to be sterile. There's no germs inside the uterus if things are working correctly. There are a few babies, and I think this is the situation for Kendall, where infection can develop even though the baby is still in the uterus, and I suspect that's how Kendall got infected.
She was a less common version of how a baby gets infected which is the bacteria living in the mother's vaginal tract climbs up, attaches to the -- not the placenta, but the sac that contains the fluid that the baby is in and then can actually go into that sac and, in the warm dark environment, grow.
Q. We've heard the term ascending infection. Is that what you just described?
A. Right, right. I think it has to do with, you know, if you think of somebody standing up, it starts down in the groin area and goes up to the uterus.
Q. How do babies like Kendall fight this infection? What is the body's response to this? What happens?
A. When bacteria are introduced into a compartment of the body where they don't belong, a cascade of immunologic

responses happen. The human cells that are encountering the bacteria are getting damaged. They release chemicals that essentially signal we're being damaged and recruit new blood cells essentially, infection-fighting cells to come to that location, and those infection-fighting cells can pull in more infection-fighting cells and can themselves release different toxins and chemicals designed to kill the bacteria.

Unfortunately, some of these cells that are designed to kill bacteria also release toxins that can cause local damage of the human tissue too, and I think it's that kind of interplay between an immune response that helps get rid of bacteria can also hurt the patient, and in this case, Kendall.

Q. We've heard some terminology here and I just want to very briefly go over this. We've heard the term white blood cells. What are white blood cells? What are their function?

A. So there are three different types of cells that float around in the blood, platelets and red blood cells and then white blood cells. White blood cells are what I like to think of as infection-fighting cells. They come in different flavors of white cells, but they each -- each of these different flavors have a specific set of activities designed to respond to an invasion due to a virus, a bacteria, a fungus.

Q. What would be the normal range of white blood cells for a newborn like Kendall?

A. The normal range is typically felt to be between 5 and 15, although in a baby who has just been born, because of the stress of birth, can drift northwards up to 20 or 22,000.

Q. We've also heard the term differential. What is the differential and what are the components of that?

A. Sure. I kind of just described there being different flavors of white blood cells. Those, in medical terminology, are counted as differential types of cells, and so a differential tells you we've got, you know, out of 100 white blood cells, we have 50 that are of this flavor, let's say, polymorphonuclear cells. I don't know if we need to get that specific, and this many are due to a different type of white blood cell and so on like that.

Q. We've heard the term neutrophils. What are neutrophils and what are their purpose?

A. Neutrophils, the longer name of which is polymorphonuclear, they are the key infection-fighting cell that rushes -- are typically the first infection-fighting cell that goes into an area where there's a bacterial infection, and they contain little granules that can be released and kill bacteria that they encounter. They can engulf bacteria, and inside them, they can kill bacteria too.

Q. We also heard the term lymphocytes, what are they and what are their function?

A. Lymphocytes are the main cell in the body that makes

antibodies, and antibodies are proteins that float around independent of cells, but that have the capacity to attach to specific types of viruses or bacteria, and so lymphocytes are typically like the second line of infection-fighting cell that comes to a site of infection.

Q. We've heard a couple other terms that I would just like you to define and we'll move on. We've heard the term bacteremia. What is that?

A. Bacteremia refers to the presence of bacteria in the bloodstream of a person.

Q. And in this particular case, we've heard that blood cultures came back showing E. coli. Would that be bacteremia?

A. Yes, yes.

Q. And then finally, we've heard the term sepsis. What does it mean to be septic or have sepsis?

A. So sepsis is a clinical picture that means that the body is having a big physiologic response to some sort of an insult, and typically it's an infection. Blood pressure can be low. Heart rate can be high. Breathing can be high. Fever can be present. Those are typically four components, not all have to be present, but those are the kind of classic four components of sepsis.

Q. Sepsis caused by E. coli, is there a particular pattern that you see with an E. coli sepsis?

A. E. coli sepsis, when it's recognized, is typically

extreme. E. coli is a fairly serious bacteria and eventually triggers all of those manifestations.

Q. And is there a typical course with E. coli sepsis or sepsis generally? Is it a situation where, you know, it just gradually onsets, or is it something that can happen rapidly? How does it work?

A. Sepsis often emerges in a very dramatic fashion, particularly in children who have the ability not to demonstrate their ill until they become very ill, so it's something where you can go from zero to 100 really quickly in terms of progressing through seeming well to being quite sick.

E. coli is definitely one of the bacteria that has that characteristic of triggering a very fast version. It grows rapidly and once the immune system has kicked in and triggered a big physiologic response, dropping blood pressure, raising heart rate, it's hard to stop that.

Q. And we've also heard a couple of other terms. Bronchopneumonia.

A. Bronchopneumonia. Bronchopneumonia is a term that simply refers to a bacteria in the airspaces of the lungs and gets in the way of gas exchange, and the function of the lungs is to take in oxygen and give off carbon dioxide.

Q. Is that one of the things you can see with an E. coli sepsis? It sets up residence in the lungs?

A. It's a classic component of E. coli sepsis in the neonate

such as what Kendall had.
Q. With regard to E. coli sepsis, what is the mortality rate of neonates who acquire an E. coli sepsis?
A. There is debate in the literature about what the precise number is probably because we are constantly trying to do better. It ranges between --
MR. PRICE: Objection.
THE COURT: Sustained. Sidebar.
(At sidebar.)
THE COURT: Mr. Price, your further objection?
MR. PRICE: I object to hearsay because I have not been provided any literature and I cannot cross-examine any literature with this witness if she is citing literature.
MS. KOCZAN: Your Honor, I can rephrase the question to ask about her experience with it.
THE COURT: I think that's what we should do.
MS. KOCZAN: I will do that.
(In open court.)
THE COURT: Ladies and gentlemen, Ms. Koczan is going to rephrase her question.
BY MS. KOCZAN:
Q. Doctor, without citing the literature, can you tell us what your experience has been with the mortality rate with E. coli sepsis?
A. E. coli sepsis is typically very serious. I can't

actually remember specific cases and give you a precise proportion of the number of children I cared for that lived and died. I've taken care of children who had both experiences after having E. coli sepsis.

Q. What I'd like to do now is focus on what happened to Kendall Peronis back in October of 2014. The jury has already heard that Kendall was born at about 5:20 a.m. and was assessed immediately after birth by Nurse Hendershot.

I want to put this document up. The jury has seen this a bunch of times. Let's put it up again. It's 1115 and if we can highlight the Apgar section up on the top, and I just want to ask you about these Apgar scores.

What do these Apgar scores tell us about Kendall's condition at the time of birth?

A. At the time of birth right at one minute, she had a fair respiratory effort which earned her a score of one instead of two which would be vigorous -- typically vigorous really crying.

She was felt to have fair muscle tone, meaning she was probably active but not with really strong kicks and such.

Her reflex, which is a response to being stimulated, was okay but not quite as dramatic.

And her skin color, when you get a one, it means your fingers and toes haven't pinked up yet. You get a two when they pink up.

Q. And then at five minutes, what was her score?
A. So there, her heart rate is in the appropriate range. Her respiratory effort is deemed to be good so she is vigorously crying. She still seems perhaps, if you are trying to interpret the numbers, perhaps a teeny bit, I don't know, floppy. She has vigorous reflexes though, meaning when she is stimulated, she responds well, and then she still probably has the duskiness of her fingers and toes.
Q. Does an Apgar score of eight indicate a healthy baby?
A. Typically, yes.
Q. In addition to receiving the Apgar scores and being assessed that way, Nurse Hendershot also did a neonatal assessment, and if we can look at the bottom left-hand side there, and if you can take a look at that.
Anything abnormal about that assessment?
A. It's interesting. Now that I'm looking at it and looking at the code, the X seems to indicate an abnormality.
Q. And we're just looking at the one on the left.
A. Okay. So no. It looks like that everything looked good. Just having made note of the baby's gender and didn't do a detailed exam of the baby's bottom.
Q. Is there any indication based upon the Apgar scores or this initial assessment that there was any reason to suspect that this baby might have an infection at this point?
A. No.

Q. Was there any reason to order antibiotics at this point?
A. No.
Q. Was there any need for this baby, based upon those Apgar scores and that assessment, not to be permitted to remain in the room with mom and go through the bonding process?
A. None that I see, no.
Q. I would like you to assume that Nurse Hendershot, the nurse who did the initial assessment, has testified that per her documentation from 6:00 to 7:00 a.m., she was in to assess mom, Kendall was with mom, and during those examinations, she would have observed Kendall and did not observe anything unusual.

Given the fact that we know that Kendall already had an infection at that point, would the absence of any symptoms during that time frame be unusual in any way?
A. Unfortunately not. Babies and children in general have an amazing ability to compensate, meaning that they can tolerate a moderate amount of illness, even severe illness, without demonstrating it. We're not so lucky as adults.
Q. We heard from the parents that when Kendall was in the room with them, she was crying continuously. First and foremost, is crying a bad thing?
A. For a newborn, it's actually part of the necessary work to transition yourself into being able to live outside in the world of air. It's part of what opens up your lungs and such

is the way I think about it. Crying vigorously is what gets you two points on the respiratory score on that Apgar system we just looked at. So crying, in and of itself, is not a bad thing.

Q. And in terms of we've heard some testimony that the parents observed certain things. If a baby was grunting, is that something that a trained medical professional would be able to hear?

A. Yes.

Q. If a baby was flaring, is that something that a trained medical personnel would be able to note?

A. Nasal flaring?

Q. Yes.

A. Yes, it is.

Q. When we talk about nasal flaring, what exactly are we talking about?

A. It's literally just the outer margins of your nostrils go out and it's an effort just to suck in more air.

Q. And we've heard about retractions. Is that something that a trained medical professional would know what it was and be able to recognize it?

A. Yes, yes.

Q. Was there any evidence in any of the records that you saw before 7:25 a.m. that Kendall was having any of those?

A. I didn't see any notations to that effect.

Q. Problems. The jury heard yesterday from the nursery nurse, Barb Hackney, that sometime before 7:00 a.m., somewhere between 6:50 and 7:00, Nurse Hendershot brought Kendall over to the nursery and that Nurse Hackney took a set of vital signs. I'd like to put those up and just ask you about that. That's 1165, if we can put those on the screen.

These are the initial set of vital signs that Nurse Hackney took at 7:00 a.m. when Kendall arrived in the nursery but were documented by Nurse McCrory. My question is simply this: Are these normal vital signs?

A. They are.

Q. Did these vital signs indicate that there should be at that stage any suspicion of infection or respiratory distress or what we know occurred later on?

A. No.

Q. In addition to those vital signs, Nurse Hackney also testified that she did not observe anything abnormal, no respiratory distress, grunting, flaring, retractions, when Kendall was brought over.

Again, same question. Would that be unusual given the nature of this particular infection?

A. No.

Q. Now, based upon your review of the records, when was the very first time that there was any evidence whatsoever that Kendall was having issues that might be related to an

infection? And if we can put up document 1167, that may help, and just highlight this page here. Down below there, the 7:25 a.m. note.

A. So here is documentation that I think a trained neonatology nurse or physician would recognize as being concerning with the grunting, flaring and retracting and appears to be in pain.

Q. There's another page here. If we could put that up too. That would be 1172. This is a further part of that note. If you can put that side by side and highlight. I think it's the bottom of that page there. Keep going, I believe. It's below that.

There's a note there that says the doctor was -- Dr. Heiple was called, I believe. Is that 1172? That's it, at the bottom there.

This is a further part of that same 7:25 a.m. note, and as we've talked before, is it unusual that now, about two hours -- a little over two hours has passed before there were any signs or symptoms that might indicate infection, given what we know later happened?

A. No. The baby, in the first hours, is undergoing a physiologic switch from being able to get all they need from the mother's placenta into living independently, and what I suspect is that as that physiologic switch was happening, the stress of the infection was slowly emerging.

Q. I would like you to assume that Dr. Heiple, who was the resident who was called here, testified in here, in the courtroom, that he was called by Nurse McCrory, went up to the nursery to assess the baby shortly after he was called, and when he arrived, the baby's O2 saturation had increased from that 81 percent that we saw originally up to 94 percent and that she looked okay.

I would further like you to assume that Dr. Jones has testified that when she arrived around 8:00, she was concerned because the baby's O2 requirement had increased and there were some respiratory symptoms.

Again, is this course that the doctors described, what Dr. Heiple saw, and there's some dispute as to what time it was, 7:45, you know, before 8:00, somewhere thereabout, is this course though consistent with what you have seen in babies with E. coli sepsis infection?

A. By -- I don't know if I'm allowed to ask a question, but do you mean like a rapid course? Like it moving quite quickly and changing quite quickly?

Q. Yes.

A. Yes, that is typical, and as I said, the baby is undergoing a physiologic switch from being in utero to being out in the world, and all of a sudden, as the body's systems begin to take over for living out in the world, they are encountering a lot of inflammation in the lungs presumably and

saying like, whoa, this is not something that's easy to deal with.

Q. And again, I'd like you to assume that Dr. Jones has testified, as she documented in her record, that when she got in, she immediately decided that this baby needed to be transferred to West Penn Hospital and then she ordered labs, cap gases, an IV, antibiotics, including ampicillin and gentamicin.

Are those all appropriate actions?

A. Yes.

Q. One of the things that she did order was some lab work, and I want to ask you about that, and if we can put up 1140 and 1141, if we can put that side by side. This is some of the lab work that she ordered which included the differential.

If you can explain to the jury what this is and what this tells us about the duration and extent of this infection.

A. So actually, for me what's most helpful is to look over on the right-hand side in the middle. Does this work? Right there (indicating).

The white blood cell count of 8.3, so that's in the relatively normal range, although it does indicate low, but 8.3 is normal white blood cell count in my mind, and then the differential, if we could go over to the other page now, right here (indicating), and so what this shows is that there is three percent neutrophils, which is low, and then a very high

lymphocyte count, which is relatively high likely because there's not very many neutrophils to fill in their normal complement.

Q. What does the low neutrophils tell you about the infection, how long it had been going on, how far it progressed?

A. This is not a normal pattern, and in a normal pattern, you would see maybe equal numbers of neutrophils or equal percentages of neutrophils and lymphocytes, so something has been going on to drive those neutrophils down to this level from 30, 40 percent down to three percent.

Q. One of the things that Dr. Jones ordered was the antibiotics, the ampicillin and gentamicin. First and foremost, were those appropriate antibiotics choices?

A. Those are the classic antibiotics to be given for a just born baby who may be having an undiagnosed infection.

Q. We have heard some testimony that those antibiotics, the ampicillin didn't get started until sometime 9:00 or shortly thereafter, and then the gentamicin was hung around 9:50 after the ampicillin had infused.

Do you have any issue with the timing of the administration of those antibiotics?

MR. PRICE: Objection, Your Honor.

THE COURT: Sidebar.

(At sidebar.)

THE COURT: Mr. Price?

MR. PRICE: Nowhere does she comment that the late gentamicin is an acceptable dose. I mean, I don't know what she is going to say.

MS. KOCZAN: Your Honor, she offers the opinion that the earlier administration of antibiotics would not have made any difference in this case. I'm going to have her explain that and that's why I asked the question the way I did, but she clearly offered the opinion that it would not have made any difference in the outcome.

MR. PRICE: Early but not later.

MS. KOCZAN: What's that?

MR. PRICE: I understand the earlier, with which she already testified to at the time of birth, but my point is here now she is talking about the later administration of it.

MS. KOCZAN: No. She talks in her report globally that earlier administration of antibiotics would not have made any difference. She clearly states that. And, Your Honor, it's in the last paragraph -- I guess next to the last paragraph of her report at the bottom.

THE COURT: So document 122-1 page 2 of 34, "It's also my opinion to a reasonable degree of medical certainty that infection was established prior to Kendall's birth and that the disease process would not have been reversed by earlier administration of antibiotics."

MR. PRICE: I understand that. That's my point is she talked about earlier administration of antibiotics at the time of birth and she hasn't made any comment about earlier administration at 9:50.

MS. KOCZAN: She talks globally about it. That's what that says.

THE COURT: It's very generic. It's very broad, and as I've told you repeatedly, you all had the opportunity to depose these experts prior to going to trial. You all chose not to do that.

(In open court.)

MS. KOCZAN: Could you please read that question back? Never mind. I remember it.

Q. My question was this: We've heard testimony and looked at some records that indicate that the ampicillin was not hung until sometime 9:00 or a little afterwards and that the gentamicin was not hung until after the ampicillin had infused somewhere around 9:50 a.m.

Do you have any issue with the timing of the administration of the antibiotics under these circumstances?

A. Typically, we want to get antibiotics into a patient within one hour after they have been ordered. That is a national target, and so I don't know what time precisely the orders were written, but that sounds as though it is, you know, close, if not within that range.

Q. The antibiotic order was actually written by Dr. Heiple at around 8:32. Now, let me ask you this: This baby had one IV. Can you run these simultaneously, or do you have to let the one go in and then the other?

A. I don't know about amp and gent being compatible, meaning they could be simultaneously infused. There often is a rate limiting step, in terms of the caliber of the baby's vein, like how much you can pump in how quickly, so that often is what the rate limiting step is, like how much you can get in there, how quickly.

Q. Can you explain just briefly to the jury without going into any great detail what this baby's course was after the initial evaluation by Dr. Jones and then when she came back after talking with the parents about transfer? Just generally what happened after that?

A. The baby rapidly, rapidly deteriorated, having rapid escalation in the amount of oxygen that the baby was requiring, and even with maximal oxygen, was not getting enough into her bloodstream.

Her metabolism became more and more out of whack, and that's something you can see if you look at what the PH of her blood was over time. It should be 7.4, and at one point, it was 7, and then it was below 7, all of which are very concerning.

Q. Let me put a document up and this may help too for the

jury to follow along. It's 1120 and 1121, if you can put that side by side.

That is Dr. Jones' summary of the events, if you need to refer to that. I didn't mean to interrupt you, if you can continue.

A. So in addition to deteriorating metabolism, deteriorating respiratory support, requiring more and more oxygen, the baby ultimately needs to be intubated to provide, in addition to more oxygen pressure which is what you get with intubation and using a mechanical ventilator to push the air more -- more air into the baby's lungs, the baby, I believe is given a dose of something called surfactant, which is typically present in babies who are born at term but can -- but helps a baby breathe if they are born preterm. Sometimes it's done in a baby like this whose lungs just aren't working in the off chance that that will help them.

Q. One of the other things that we saw given was something called nitrous oxide. What is that and why is that given?

A. Nitric oxide is a gas, but it's a drug given as a gas mixed in with the oxygen that's being delivered, and it has this unique effect of causing the blood vessels that go through the lung tissue to dilate, and the reason that's helpful in a case like Kendall's is there's a lot of signals in her respiratory course that her blood vessels in her lungs are all clamped down, back like they would have been before

she was born, and that's part of the reason why the oxygen isn't getting into her bloodstream.

Q. And if you could continue, in terms of her course, what happened as it progressed?

A. There were many efforts to reverse these things. Giving the nitrous oxide and the surfactant were important efforts to try and address the deteriorating lung function.

She is given what are called boluses of normal saline, so a quick infusion of a large volume of fluid to expand her blood volume in the setting of having low blood pressure. She is given some bicarbonate, which is like bicarbonate soda used to correct the low pH in her blood.

So those are the major interventions that were undertaken until she got very, very sick.

Q. One of the things that we saw too is that during the course of this resuscitation, there was some pulmonary hemorrhaging.

What is that and what is the significance? Why does that happen?

A. Pulmonary hemorrhage means that there has been leakage of blood from the blood vessels that sit at the base of the air sacs of the lung into the lung, and it's been in a sufficient amount that it's coming bubbling up, and in this case was visible, I think, in her endotracheal tube.

It's a concerning sign. It means that the blood vessels

aren't able to keep the blood where they belong separate from the tissue. This is something that happens with very advanced sepsis. It's a very concerning sign.

Q. In terms of the entire course, you know, what occurred during the resuscitation, in your opinion, is that consistent with an overwhelming E. coli sepsis?

A. It is, yes.

Q. And in terms of the actual mechanism of how she died, what did happen? What were the physiological changes that ultimately led to her death?

A. I think, you know, a variety of things that you can see from this are that she -- her heart is being driven to beat faster and faster because her blood pressure was low, because it's being stimulated by the infection and the inflammation that the infection is causing.

Her lungs are kind of shutting down. At first, they are not accepting oxygen, and then they start being unable to keep separate the gas from the blood with the pulmonary hemorrhage, and then the tissues of her body aren't getting the oxygenated blood they need and that's why her pH is falling low, all of which are very concerning signs of bad sepsis.

Q. It has been suggested and testified here in the courtroom by plaintiffs' experts that if she had an earlier administration of antibiotics, it would have changed the course. Do you agree with that?

A. Unfortunately, I don't.
Q. Can you tell the jury why?
A. I think this process was very well established at the point it was recognized, and there's a very short period of time between that and when the baby was born, and I think that this is the kind of picture that you can't reverse when the physiology of the body is so out of whack. It's not just about killing bacteria. The bacteria stimulated a whole cascade of physiologic changes in the body, and killing of bacteria won't reverse those.
Q. And just more to explore that a little bit further. There has been some suggestion that, you know, if Dr. Heiple would have ordered antibiotics right away, that somehow this would have been different.

Do you agree with that, and keep in mind Dr. Heiple was there somewhere between maybe 7:45, 8:00, something like that? Would that have changed anything?
A. At that point, if I'm remembering the timeline correctly, Kendall was already having really profound issues getting oxygen into her system, and that we saw because she needed such a high concentration of oxygen, and to me, that's, even though it's just a concentration of oxygen in the blood, that's a big signal that things are seriously out of whack in terms of her lung function.
Q. So just in terms of the response to that question, would

it have made any difference at that stage?
A. I don't think so.
Q. Let's assume the antibiotics were started at 8:00. Would it have made any difference at that time?
A. No.
Q. 8:30, would it have made any difference at that time?
A. No.
Q. 9:00, 9:50?
A. No.
Q. In terms of this entire picture that we've discussed here today, is this typical of what you see with an E. coli infection in terms of the timing of these symptoms, the rapidity of the deterioration and ultimate death? Is this the typical course?
A. This is definitely, you know, a severe case of E. coli sepsis, but it is a typical case. It's shocking how rapidly this progresses.
Q. Just to conclude, we've heard all this about, you know, the faster you get antibiotics in, the better it is, that type of thing. I think we would all generally agree with that.
In this case, would that have been the situation?
A. The goal of getting antibiotics in quickly to treat an infection really has to do with getting them in before bad secondary complications develop. I don't see that window of time in Kendall's story. I think we see signals that Kendall

was having big physiologic reactions to this infection, but that they weren't manifest in ways that the people caring for her could see.

Q. Have all the opinions that you've rendered here today been rendered with a reasonable degree of medical certainty?

A. Yes.

MS. KOCZAN: Thank you. Those are all the questions I have.

THE COURT: Mr. Colville, any questions of this witness?

MR. COLVILLE: No questions.

THE COURT: Mr. Price?

MR. PRICE: Sure.

CROSS-EXAMINATION

BY MR. PRICE:

Q. Dr. Coffin, I'll start out with, you mentioned that part of your work like you are doing here today is medical-legal work, and you said that you do a percentage of your cases for patients, for plaintiffs. Can you tell me what percentage that is?

A. I haven't calculated it. In the past year, I can think of two specific cases that I've reviewed.

Q. Just so the jury understands, reviewing is different than actually coming to court and testifying?

A. Right.

Q. Did you actually come to court and testify for either of those patients or the plaintiffs?
A. No.
Q. I thought it was the policy of the Children's Hospital of Philadelphia to not allow the doctors to write reports for patients, that they could only -- you could only testify on behalf of defendant hospitals and physicians.
A. I'm not aware of that policy.
Q. Okay. Can you tell -- I know that we have your documents that you've given us about your testimonial history. Over the last five years, how many cases have you testified on behalf of the plaintiff or the patient?
A. Zero.
Q. Do you remember the last time you did?
A. I never have done that. I've only testified once before in court.
Q. Now, it has been the plaintiffs' position in this case that Kendall suffered respiratory distress due to a massive aspiration of meconium. Do you understand that?
A. Do I understand, yes.
Q. If you could bring up M01. This is just an exhibit which we used with one of our experts, and I'll explain it to you. On the left-hand side is a baby that has inhaled a little bit of meconium but it doesn't get all the way down into the alveoli. I hate that word.

A. Air sacs.
Q. Thank you. Air sacs. On the right-hand side, the baby has ingested a lot of meconium so it's gotten all the way down to the bottom air sacs. The only thing I will correct for you is our expert said that my drawing of the lungs was too small because the lungs would actually expand.

The reason why I'm asking you about this is he explained that, in a situation where you have meconium all the way down into the bottom of the air sacs, that it's sort of like a bell valve. In fact, Dr. Jones testified to this in the sense that air will come in. It will go into the body but getting it back out is difficult.

Do you understand that to be the same?
A. I'm not a neonatologist, but yeah, I think that is one of the ways that meconium aspiration can cause damage.
Q. And if you had problems like that, from your understanding, the body then in a baby would become acidotic?
A. Uh-huh.
Q. You have to say yes for the court reporter.
A. Yes. Sorry.
Q. And acidosis is something that the pH is off balance and the baby's organs can start being affected, things of that nature, correct?
A. That's correct.
Q. Now, if a baby becomes acidotic, that throws, on top of

things, that the baby has to battle to stay oxygenated, correct?

A. Correct.

Q. So in a situation like this exhibit on the right-hand side, if a baby has meconium deep in its lungs, every breath it takes, it's fighting to get more oxygen into its system, correct?

A. I think that's possible. I think it depends on how much and how many of the air sacs would be involved, but --

Q. Right. Exactly. That's for debate. You know, the pathologist said it was massive. The defense expert says it's not. We'll leave that for the jury's decision, but my point is that if you have a condition like on the right-hand side where the lower air sacs are filled with meconium, that would hinder a baby's ability to fight off other conditions, correct?

A. Well, it certainly hinders gas exchange.

Q. Right. And you need good gas exchange to help fight off any type of infection too, correct?

A. Correct.

Q. So while the cause of death in this case was E. coli sepsis, as you know from the pathologist's report, he said it was associated with a massive aspiration of meconium, correct?

A. Right.

Q. So you would agree with me that if this baby didn't have

the massive aspiration of meconium, the only issue would be whether the baby could have fought off the infection, correct?
A. I guess so, yeah.
Q. Because having both conditions, the baby was trying to fight to breathe as well as fight an infection, correct?
A. Well, because the infection was in the lungs, there was perhaps two things going on in the lungs simultaneously.
Q. Right. And so the longer that this condition went on, the tougher it was for Kendall to fight, correct?
A. Certainly things progressed, and that's the sad story. Things did progress.
Q. Right. That's the whole issue about the progression. I know that you said the infection had the upper hand, but you didn't mention the meconium in that statement, and I guess the infection had the upper hand, but with the meconium, it had a really good head start, a lot of --
A. I don't know the extent, if any, the meconium played in the -- in changing the features that I see of progressive infection.
Q. Okay. Yeah. I understand your point that the meconium wasn't the infected material as much as the meconium was in the bottom of the lungs and that meconium is what Kendall was fighting her air exchange, the acidosis, and that all hinders her ability to fight an infection, correct?
A. While meconium alone might cause some of those things, I

think that the infection played a really big part in her struggling to get the oxygen she needed for her deteriorating pH, her rising heart rate. I see those as signs of progressive infection.

Q. Okay. But would you disagree if an expert had come in here and said that having massive aspiration of meconium with meconium in the bottom air sacs would cause acidosis, your pH to go into an acidotic state and that you would have organ failure and organ problems as a result of that?

A. Certainly babies can have devastating illness, total body illness as meconium aspiration.

Q. I know you heard one set of facts and I want you to assume a little bit different set of facts. I want you to assume that no nurse came into the baby's room from 5:30 to 7:00 in the morning. I want you to assume that there are no notes about the baby's condition from 5:30 to 7:00, and I want you to assume that when the baby got to the nursery at shift change, Nurse McCrory looked over at Kendall and said she is breathing fast.

Within 15 minutes, they found the oxygen level was 81, grunting, flaring and retracting, appears to be in pain, nasal flaring, substernal retractions, respiratory is labored, abdominal muscle use, subcostal retractions, the breath sounds were coarse, anterior and posterior, she had a dusky appearance and they had to put her on an oxy hood at 64

percent oxygen.

So since you are here as an expert, what can you tell me about Kendall's condition for the two hours previous?

A. With what you've just described, you don't have information.

Q. That's the whole point in this case, that you can't tell me here while you are sitting there what Kendall's pulse ox was at 5:30, 5:45, 6:00, 6:15, 6:30, 6:45, 7:00 or 7:15, correct?

A. Correct.

Q. Now, with regard to antibiotic administration, you are not suggesting that Kendall was so sick that even if a doctor had recognized signs of some type of respiratory distress at 5:30 or 6:00, that they wouldn't try antibiotics, would you?

A. If you are asking if Kendall was recognized to be -- have a high likelihood of being infected?

Q. Yes.

A. Would they have started antibiotics?

Q. Yes.

A. Yes, they would have.

Q. So if a pediatrician had been in Kendall's room and noticed that Kendall had some type of respiratory distress, you would agree that the initial workup is giving oxygen and working up for a neonatal sepsis, which is giving antibiotics, correct?

A. Right.
Q. And you would agree that if a pediatrician saw Kendall at 5:30, 6:00 and recognized those symptoms, that she would have gotten the antibiotics earlier, correct?
A. If they were present, correct.
Q. And you would agree that if Kendall got antibiotics earlier before she started showing the 81 percent, that there was a chance that the antibiotics would have an effect on the E. coli infection, correct?
A. Correct.
Q. So earlier recognition of this infection, an earlier administration of antibiotics would have given Kendall a chance to survive, correct?
A. I don't know the size of the chance, but what appears to have been present when she is first assessed in that nursery appears to be very longstanding. I mean, she had barely any neutrophils at that point. She had a low pH. She had low oxygen. It seems as though this must have been going on probably since before she was born.
Q. Understood. But my question was specific with regard to recognizing respiratory distress and treating it before 7:20, and you are saying it might be a small chance, but there was a chance, correct?
A. Correct.
Q. Dr. Jones described the scene in the nursery -- I'll

represent this to you. This is what her testimony was, that when she walked into the nursery, she said that it was a crisis. Okay.

A. Okay.

Q. Now, you would agree with me that it's always better to treat a patient before it turns into a crisis, correct?

A. Correct.

Q. And in fact, that's what your testimony was, that a workup of Kendall before she showed these really bad signs at 7:25, would have been preferred, correct?

A. Yes.

Q. Now, I know that you were asked a question with regard to the timing of the gentamicin, and you were given one set of facts.

Dr. Jones has said that she came in to the nursery at 8:00 in the morning. She said that at 8:00 in the morning, she gave verbal orders for the blood gases, for chest x-ray and for antibiotics. I want you to assume 8:00 is when she made that order.

A. Uh-huh.

Q. You testified that typically antibiotics should be given within one hour of an order?

A. Correct.

Q. So if these antibiotics took one hour and 50 minutes after that verbal order, you would say that that was a delay?

A. Yes.

MR. PRICE: That's all the questions I have, Your Honor.

THE COURT: Ms. Koczan, any redirect?

MS. KOCZAN: Yes, I do.

REDIRECT EXAMINATION

BY MS. KOCZAN:

Q. Doctor, I'd like to begin by going back and asking you about the acidosis that was noted. Mr. Price was asking you questions about was that associated with the meconium.

What do you believe caused the acidosis that was noted during the course of the resuscitation efforts?

A. I think it was overwhelming infection.

Q. And you were asked a number of questions about if this had happened at 5:00 or 6:00, whatever, based upon your review of the records, is there any indication here in the records, and let's start with 5:00, 5:20, when this child was born, is there any indication that there was anything going on for which a workup should have been initiated?

A. No. I didn't see anything that should have triggered a workup in what I reviewed.

Q. Is there anything that you saw in the records that indicated that an administration of antibiotics should have occurred sometime around the time that this child was born?

A. No.

Q. Now, we talked before about Nurse Hendershot's testimony, that she went in, that she observed this baby and did not notice anything. Nurse Hendershot, I'd like you to assume, is a nurse with 30 years of experience and is neonatal resuscitation trained.

Would you expect a nurse with that degree of experience and that training to be able to recognize signs and symptoms of respiratory distress?

A. Indeed.

Q. And I'd like you to assume that Nurse Hendershot has testified that had she noticed any of that, she would have done a couple of things. Number one, she would have brought the child to the nursery, and number two, there would be some documentation.

Did any of that occur in this case?

A. I didn't see any.

Q. We went over before Nurse Hackney seeing the baby at 7:00, taking vital signs. Again, is there any indication at 7:00 that there was anything going on that should have triggered an investigation or the administration of antibiotics?

A. No, not at that time.

Q. Based upon the records you reviewed, was the very first time that anything was going on that indicated that something was going on such that antibiotics might be indicated, was that around 7:25?

A. I would probably need to look at it precisely, but I think that's when we began to see the changes documented, with the baby having retractions and flaring and such.
Q. So was there any reason to suspect infection, begin antibiotics before they were in fact given in this particular case?
A. No.
Q. I want to go back and ask you again, in terms of the administration of those antibiotics, you were asked questions about, well, if they weren't given until an hour and 50, was that a delay. If indeed there was a delay, did that make any difference in this case, given what we know here?
A. No, I don't think so.
Q. And why is that?
A. I think at the point that this baby moved into the NICU that the die had been cast. The multiple organ systems were exhibiting kind of the secondary complications with high heart rate, low blood pressure, inability to get oxygen into the blood.
Q. You were also asked a chance, even a small chance. Given the picture that we see as documented in this chart and has been testified to by the medical professionals, was there any chance for Kendall, given this infection?
A. I honestly don't know for sure. This is a devastating infection and it progressed so rapidly. Unfortunately,

there's a tempo of inevitability. Things are getting worse and worse and worse.

Q. So given that progression, would the outcome have been any different here?

A. I don't think so.

Q. And again, is that an opinion you hold with a reasonable degree of medical certainty?

A. Yes.

MS. KOCZAN: Thank you.

THE COURT: Mr. Colville, at this time any questions?

MR. COLVILLE: No questions.

THE COURT: Mr. Price, anything further of this witness?

MR. PRICE: Sure.

RECROSS-EXAMINATION

BY MR. PRICE:

Q. I'm not going to go over and have you assume one set of facts and have a question. The jury has heard all this and they can make a decision based upon you believe this nurse or you believe the parents, what was going on in the room. But I guess I wanted to ask one other question with regard to Nurse Hendershot.

You saw all those Apgar scores. When Kendall was born, you say that it was a normal healthy baby, right?

A. Right.

Q. But at the same time, she has this massive infection going on that you say could not have been addressed, correct?
A. Correct.
Q. And from part of what you say with regard to this infection, you say that it was so far advanced that nothing could be done, yet this baby has normal Apgar scores, correct?
A. Correct.
Q. Now, part of this infection would be that the lungs itself would be filling up with fluid and things and just having infection in the lungs, correct?
A. Yes, but at the same time, in the first hours of life, the baby is expelling the fluid that was in the lungs from their life in utero.
Q. I guess my question is that what we are looking at is, unfortunately, we had nurses who were examining this child and gave normal Apgars and gave normal respirations to a baby that you are telling the jury had an overwhelming infection at the time of its birth?
A. Right.
Q. And you were just asked some questions with regard to whether or not earlier antibiotic use could have affected this case and I wrote down your answer. You said I don't know for sure. Previously you said that there was no way.
A. I apologize if I used the phrase no way. I think, for me, it's impossible to say with 100 percent certainty. I don't

think this baby had a chance. I really don't. I wish it was otherwise. I really don't. I'm trying to express myself as clearly as possible, but that's what my opinion is. I don't think this baby had a chance.

Q. And that's based upon the assumptions in the record that Ms. Koczan pointed out to you. But based upon the assumptions of the records that I gave you, if you believe what I told you about the baby's condition for the two hours before it got to the nursery, you don't know for sure whether or not there was a chance lost, correct?

A. We don't know what would have happened.

Q. Right. And that's sort of the problem here, because we don't know what the baby's condition was for two hours, right?

A. No. All we can do is look at what the baby's condition was when it's been charted.

Q. Right. And there's no charting from 5:30 until 7:00, correct?

A. I would want to, like, eyeball it completely, but I don't think so.

MR. PRICE: That's all the questions I have, Your Honor.

THE COURT: No further questions for Ms. Koczan or Mr. Colville, correct?

MR. COLVILLE: No.

THE COURT: They are indicating no. Doctor, you may

step down. I trust the doctor can also be excused at this time. Dr. Coffin, thank you for your appearance and safe travels home.

(Witness excused.)

THE COURT: Ladies and gentlemen of the jury, we're going to take our midmorning break at this time. We have been working prior to you all entering, and so to that end, we're going to break until quarter to 11:00. I understand we'll next be hearing from Dr. Ringer.

Once again, leave your pads and your binders with exhibits on your chair. Don't communicate. You don't research. You don't talk yet. Enjoy your break. We'll see you back here at quarter to 11:00.

(Jury excused.)

(Recess taken.)

(Jury present.)

THE COURT: Doctor, you are going to come up here. Ladies and gentlemen, as I indicated, Dr. Ringer is our next witness. Mr. Galovich, please administer the oath.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Steven Allen Ringer, R-I-N-G-E-R.

(Witness sworn.)

THE COURT: Thank you, Mr. Galovich.

Dr. Ringer, watch your step as you climb into the

witness box. It's a little uneven there. Once you are situated, you can change the microphone so you are speaking into it. It slides. It can go up and down as well. There's also water there in case you need it.

THE WITNESS: That I do.

THE COURT: It appears you have been given a binder or you have a screen there. I'm not sure what that is.

THE WITNESS: Screen.

THE COURT: Ladies and gentlemen, as I've given this limiting instruction before, one more time, you are now going to hear testimony concerning opinions from Dr. Steven Ringer, who is a physician. He'll offer his opinions because of his knowledge, skill, experience, training and education in the field of neonatology as well as the reasons for his opinions.

Once again, in weighing this opinion testimony, you can consider all of his qualifications, the reasons for his opinions and the reliability of the information supporting those opinions as well as any other factors I'll ultimately discuss with you in my final instructions about how you should weigh testimony of witnesses.

The opinion of Dr. Ringer should receive whatever weight and credit, if any, you think appropriate given all of the evidence in this case. You can also disregard his opinions entirely if you decide that they are not based on sufficient knowledge, skill, experience, training or

education.

You can also disregard his opinions if you conclude that the reasons given in support of his opinions aren't sound, or if you conclude that the opinions are not supported by the facts shown by the evidence or if you think that the opinions are outweighed by other evidence in this case.

Once again, in deciding whether to accept or rely upon these opinions of Dr. Ringer, you can consider any bias that he may have, including any bias that can arise from evidence that Dr. Ringer has been or will be paid for reviewing this case and testifying as well as any other evidence that Dr. Ringer testifies regularly and makes any portion of his income from testifying in court.

Ms. Koczan, you may proceed.

MS. KOCZAN: Thank you, Your Honor.

STEVEN RINGER, M.D. a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KOCZAN:

Q. Good morning, Doctor.

A. Good morning.

Q. Can you please introduce yourself to the jury?

A. Sure. My name is Steven Ringer. How much more should I say?

Q. What is your occupation?

A. I'm a neonatologist.
Q. And are you licensed to practice medicine?
A. I am.
Q. Is that in what states?
A. In New Hampshire and Massachusetts.
Q. Can you tell the jury what your current academic positions are?
A. Sure. I'm a professor of pediatrics at the Geisinger School of Medicine at Dartmouth.
Q. In addition to that position, do you also hold an appointment at Harvard?
A. Not anymore. I did.
Q. Did you previously?
A. Yes, I did.
Q. Where do you reside?
A. I reside in Hanover, New Hampshire.
Q. Would you tell the jury about your education? Start with undergraduate, bring us up through your internship and your fellowship.
A. Sure. My undergraduate degree was at Brandeis University just outside of Boston, and then I went from there to Case Western Reserve University where I received my M.D. degree and my Ph.D. degree. My Ph.D. was in biochemistry. I finished those in 1982, and I stayed in -- that's in Cleveland. I stayed in Cleveland at Rainbow Babies and Children's Cleveland

Metropolitan General Hospital for my residency in pediatrics, finishing that in 1985.

I then went back to Boston to what was then called the joint program in neonatology at Harvard Medical School which was a program in neonatology that involved Brigham and Women's Hospital, what was then the Beth Israel Hospital, and the Children's Hospital in Boston, and I finished that in 1988.

Q. You mentioned that that was -- I think you were neonatology; is that correct?

A. Yes.

Q. I've also heard perinatal medicine. Is that the same thing?

A. Yeah. Well, so yeah, our board certification is called neonatal perinatal medicine, and perinatal care meaning care around birth, is a field that we share with obstetricians and there are some specialists in obstetrics called perinatologists.

Basically the division is we're coming at it from the side of the baby. They are coming at it from the side of the mother, and obviously, the two are interlinked, so we both are involved to some extent in the middle, if you will.

Q. In terms of neonatology, what does that field encompass? We heard about pediatrics and pediatric infectious disease. What is neonatology?

A. Well, the classic definition of a neonate is a baby up to

28 days of age, but what modern neonatology means is that we care for babies sometimes before birth, during the process of birth, and if they require hospitalization, immediately after birth. We care for them during that immediate hospitalization that sometimes can last several months, so it's basically the care of newborns specifically.

Q. And, Doctor, in addition to what you've already described in terms of your education, I also saw that you had some further educational experiences. Looking at your curriculum vitae, I saw that you were a scholar in medical education, curriculum planning and you also took a fellowship in medical ethics.

Would you briefly explain to the jury what that's all about?

A. Sure. The first one was a program that was offered to people who had a specific interest in the teaching part of our role as medical school faculty, so it was an intensive program or actually I think a couple of intensive programs focused on learning about education and how we could better train young physicians and medical students.

The second one is because I've always had a strong interest in medical ethics and have been very involved in it within the hospitals, and that was a program that's offered where you get additional, more formal training in that field.

Q. And were all of those programs conducted and that training

occurred at Harvard Medical School?
A. Yeah, they were.
Q. Can you tell the jury what you have been doing since you completed your fellowship?
A. Sure. After completing my fellowship, I took on a role as -- I think at that point, it was called associate medical director of the neonatal intensive care unit at Brigham and Women's, which very quickly, over a short period of time, evolved to be director of that unit. So I have always had a role, sort of an administrative organizational role, but primarily, I've been taking care of newborns in the nurseries and neonatal intensive care unit as well as being involved in some research and teaching medical students, residents and fellows.
Q. I understand that your current practice is at Dartmouth; is that correct? What are your roles and responsibilities there?
A. Yeah. Similar roles. The position at Brigham and Women's evolved to what was called the chief of neonatology or division chief of neonatology, and then I made the decision to move to Dartmouth about four years ago, where I am the chief of neonatology, and the other things are very similar.
I'm caring for patients in the neonatal intensive care unit and the nurseries as well as teaching residents, medical students and fellows.

Q. Are you board certified?
A. I am.
Q. And in what areas are you board certified?
A. In pediatrics and in neonatal, perinatal medicine.
Q. I think we've heard a number of doctors talk about board certification. I'm not sure we actually defined what that means? What does it mean to be board certified?
A. Well, it means that you've taken specific training in an area and then have passed specific qualifying examinations in that area, and when I was first board certified, the process was you took those exams and you were sort of good for life in terms of your certification unless you did something bad, I guess.

And subsequently, they've added, I think it's every ten years, recertifications for people which involve another examination, and when that program first came in, they offered this voluntary, I think it was called maintenance of certification examination, which I took, but the requirement is, you know, I'm grandfathered in.
Q. You don't have to take the recertification every year?
A. Right.
Q. What hospitals are you currently on staff at?
A. Right now, I'm on staff at Dartmouth-Hitchcock Medical Center and at Catholic Medical Center which is in Manchester, New Hampshire.

Q. You talked before about being the chief of neonatology at the Children's Hospital at Dartmouth?
A. Yes.
Q. What sort of responsibilities do you have in that position?
A. Well, it's basically responsibility for the care of newborns in the hospital, and in our particular instance, that really extends out to providing advice and support and guidance for hospitals across the region, and then facilitating the careers of my faculty members of my division as well as sort of the ongoing administration of the neonatal units.
Q. Are you a member of various professional societies and organizations in the field of neonatology and perinatal medicine?
A. Yeah. There's no real specific organization for just neonatology, but I'm a member of the American Academy of Pediatrics, which serves that role.
Q. During the course of your career, have you been the recipient of various honors and awards?
A. Yes.
Q. And can you tell the jury about a few of those?
A. God, yeah. Some of them long ago, but teaching awards, I think primarily and various other local and regional recognitions for providing, I guess, a good care.

Q. During the course of your practice, have you been invited to give lectures both nationally and internationally?
A. Yes.
Q. And can you tell the jury whether any of those national or international lectures or presentations dealt with any of the subjects we're going to be talking about here today?
A. I don't think so specifically. It's possible that in some of the teaching sessions, some of the issues related to this case came up.
Q. Do you also write?
A. Yes.
Q. Have you authored various publications?
A. Yes.
Q. Can you give the jury some idea of how many publications you have been the author of?
A. I think I've been the author or co-author of -- I forget really, but I think somewhere around 45 or 50. It sort of depends on which things get counted, including original articles in the medical literature, book chapters and educational materials.
Q. Do any of those have to do with the subjects we're talking about here today?
A. Not directly or specifically.
Q. And do you conduct research?
A. Yes, I do, a little bit less now since I moved to

Dartmouth, but yes.

Q. And what has the research generally been about?

A. Well, it's been involved with a lot of -- well, there have been several things, but a lot of it is focused on care of premature newborns. Some on issues of global health or health in developing countries, and those have been probably the primary.

Q. During the course of your practice, and I look back, and it looks like you have been practicing for about what? 31 years? Does that sound accurate?

A. I guess so, yeah.

Q. During the course of that 31 years, have you seen and treated babies that had meconium noted at birth?

A. Oh, yes.

Q. And can you give the jury some estimate of how many that you have seen babies like that?

A. Well, meconium at birth is not at all uncommon, so I mean, I would guess thousands probably.

Q. And you said that it's not uncommon. How frequently does that happen?

A. Well, around term, so generally thought of as somewhere between 38 and 42 weeks of gestation, somewhere between 12 and 15 percent of newborns will have -- will pass meconium in the process of birth.

Q. Have you also seen and treated babies who have had

meconium aspiration?
A. Yes.
Q. Meconium in the lungs. Again, is that something rare or unusual?
A. It's less frequent than it used to be, but it is not unusual.
Q. And what about babies with neonatal sepsis? Have you had the opportunity during your 31 years to care for babies with just generally neonatal sepsis?
A. Yes.
Q. And is that something that you see frequently?
A. Yeah. I mean, again, it depends on how you define frequently, but it's a well-known problem, much less common in the United States than elsewhere in the world, but still occurs, you know. We see several cases a year.
Q. And what about E. coli sepsis in particular? Have you had the opportunity to see and treat babies who have had that condition?
A. Oh, yes, I have.
Q. And can you give the jury some idea of how many of those types of patients you have treated over the years?
A. Well, probably over, you know, all the years I've been practicing, at least dozens, if not more than that.
Q. And during the course of your career, have you been asked to review medical-legal cases like this one?

A. Yes.
Q. And when did you first start doing that?
A. I think sometime around 1992 or something like that.
Q. And can you give the jury some idea of how many of those cases you've reviewed over the course of your career?
A. It would be a complete guess. I try to limit the number of cases that I accept for review, so I typically don't accept more than a maximum of ten or 12 a year, and certainly in the first several years, it was far fewer than that, so probably a few hundred, but I don't know.
Q. In terms of coming to court to testify, how many times have you done that?
A. I think maybe 25, plus or minus.
Q. And in terms of your review of cases, is it primarily for one side or the other? Plaintiffs versus defendants?
A. Not by any design, but I think earlier in my career, it seemed to be that I got more requests from plaintiff's attorneys, and now I seem to get more requests from defense attorneys, but I still review cases for either plaintiffs or defendants.

MS. KOCZAN: At this stage, I would offer Dr. Ringer as an expert in the fields of neonatal and perinatal medicine.

THE COURT: Mr. Colville, any questions?

MR. COLVILLE: No.

THE COURT: Mr. Price?

MR. PRICE: I'll reserve.

THE COURT: At this point, the court accepts Dr. Ringer as an expert in the fields of neonatal medicine and perinatal medicine. His being board certified in both pediatrics and neonatal/perinatal medicine.

BY MS. KOCZAN:

Q. Doctor, were you asked by me to review various medical records and other materials in this case?

A. I was.

Q. And as I've been doing, I'm just going to read you a list rather than have you try to remember everything that I sent you.

A. Thank you.

Q. Did you have a chance to look at the complaint that started this action?

A. Yes.

Q. Did you look at Carissa Peronis's Heritage Valley medical records?

A. I did.

Q. Kendall's medical records?

A. Yes.

Q. The West Penn Hospital LifeFlight record? Did you take a look at those too?

A. Yes, I did.

Q. Did you also have a chance to read the depositions that

were taken in this case, including those of Carissa Peronis, Matthew Fritzius, Jamie McCrory, Chelsey Paff, Katherine Gantz, Barbara Hackney, Judith Ash, Maria Hendershot, Dr. Heiple, Dr. Jones, Dr. Dumpe, Kylee Fritzius, Dr. Goldstein and Dr. Min?

A. Yes.

Q. Have you also had a chance to take a look at the expert reports, not only those of plaintiffs' experts, which were Dr. Zamore, Dr. Shore and Dr. Karotkin, but did you also have a chance to see Dr. Boyd's report?

A. I did.

Q. And Dr. Coffin's report?

A. Yes.

Q. Have you also had a chance to look at the Heritage Valley policies and procedures that are issued in this case, that being the 2.4 and the 2.21 policy?

A. I'll trust you on the numbers, but I think those are the ones I looked at, yes.

Q. Based upon your review of all of those materials, from a perinatal neonatology perspective, can you tell the jury what you believe this case to be about?

A. Well, this is a case about a term newborn with E. coli sepsis that progressed rapidly after birth and unfortunately led to her death.

Q. And based upon your review of those records, did you form

certain opinions about the care that was provided here?
A. I did.
Q. And the first opinion that I want to ask you about was with regard to attendance by a pediatrician at the time of birth. Let me just ask you this question: Did you form an opinion as to whether either Dr. Dumpe or the nursing staff were required or should have called a pediatrician to attend Kendall's delivery, given the fact that there was meconium that had been noted during labor, that there was a use of a vacuum extractor and that Dr. Dumpe did a prophylactic performance of the McRoberts Maneuver?
A. I did.
Q. What was your opinion?
A. My opinion was that, at least from looking at the policies, they weren't required to summon a pediatrician.
Q. And even if they weren't required to summon a pediatrician, under the -- given those chains of events, would it have been appropriate or was it necessary?
A. I don't think it was necessary. That decision is typically at the discretion of obstetricians and/or obstetric caregivers, so I don't think it would have been inappropriate for them to do it, but I don't think that, under those circumstances, it would have been necessary or usual for that to happen.
Q. The mere fact that meconium was present, does that require

a pediatrician to be present?
A. Well, that's a great -- that's been a great debate in neonatology, but it doesn't require a pediatrician. I think the requirement is that actually for all deliveries that there should be someone there who is capable of initiating resuscitation that a newborn needs, and with meconium, if there's someone there who has skills in intubation, in 2014, that was recommended.
Q. And, Doctor, if someone is neonatal resuscitation trained, would that be an appropriate person to have present at delivery?
A. Yes. I mean, the neonatal resuscitation program or NRP is an educational program designed to ensure that caregivers are trained, and if they've completed the course and maintained their engagement, then they are perfectly adequate. I think it varies from hospital to hospital as to what their exact style is, but, you know, who gets invited to different births, but having NRP -- I'll use the term certified even though NRP hates that term. People who completed NRP training is the standard.
Q. Okay. And in this case, are you aware that Maria Hendershot, the delivery nurse, was NRP trained?
A. Yes.
Q. As was Dr. Dumpe?
A. That's correct.

Q. Would that meet the appropriate standard to have those types of --
A. I believe so, yes.
Q. Based upon this child's condition at delivery, and we'll take a look at the records later, but do you have an opinion as to whether the administration of antibiotics would be necessary at that time?
A. I do.
Q. And what is that opinion?
A. It wouldn't have been.
Q. If a pediatrician had been called, in your opinion, would there have been anything for the pediatrician to do at the time of Kendall's delivery given her condition and the assessments done at that point?
A. No, not more than the usual things that were done.
Q. Now, given Kendall's condition at the time of birth, the Apgar scores and the assessment, do you have an opinion as to whether it was appropriate for the staff to allow Kendall to stay with her mom and dad and bond at that time as opposed to going to the nursery or anything else?
A. I do.
Q. What is your opinion on that?
A. My opinion was that it was entirely appropriate.
Q. And we've heard lots of testimony about lack of documentation regarding Kendall's condition from 5:20 until

she was brought to the nursery at 7:00 a.m., that there were no additional assessments done.

Is that the typical course in these circumstances?

A. Yes. In my experience, that's a typical course in the first hour or so after birth when you are trying to facilitate interaction between what, by all indications, appears to be a healthy baby and her parents.

Q. Did you also form an opinion as to whether there was any evidence in this medical record or based upon the testimony of the medical professionals that there was anything going on with Kendall prior to 7:25 a.m. when she was assessed in the nursery?

A. I did.

Q. What was your opinion?

A. I couldn't find any indication of a problem during that time period.

Q. Did you also form an opinion as to whether the actions of the resident, Dr. Heiple, were appropriate in keeping with the standard of care?

A. Yes.

Q. And what was your opinion with regard to that?

A. My opinion is that they looked to be appropriate. He was called and evaluated the baby in short order. I think all of that was appropriate.

Q. What about Dr. Jones and her actions? We've heard some

testimony in this case from the plaintiffs' experts that they have no criticisms of what Dr. Jones did once she arrived, that they thought she did a great job. Do you agree with that?

A. I do.

Q. Do you also have an opinion as to what caused Kendall's death?

A. Yes.

Q. What is that opinion?

A. E. coli sepsis.

Q. And do you have an opinion as to whether earlier treatment, including the administrations of antibiotics, would have made any difference in Kendall's outcome, given that E. coli sepsis?

A. I do.

Q. What is your opinion?

A. In my opinion, earlier administration would not have changed the outcome in this case.

Q. And can you tell the jury why you hold that opinion?

A. Well, I think for a couple of reasons. I mean -- and I suppose it all depends on what "earlier" means. I think, first of all, there's evidence that the infection had been developing for a long period of time, I mean, before labor and delivery or at least the last several hours, and so in an infection that has progressed to that point, it's unlikely, in

my opinion, that a difference of an hour in antibiotic administration or a couple of hours would have made a difference, and I see no indication for administering antibiotics or thinking about administering antibiotics earlier than that, so that's -- I think I've answered your question.

Q. I think you have. What I want to do now is switch gears for just a minute and talk about neonatal sepsis and particularly E. coli sepsis. You said you have experience with that.

Can you tell the jury generally, and they've heard what it is, can you tell the jury generally what the course is with neonatal sepsis caused by E. coli? What happens? The general course.

A. Sure. To the best of our knowledge, I mean, E. coli is a common bacteria. We all carry it in our bodies, and most of the time, as I think we would probably all understand, it's a friend of ours, you know. It's doing its job while we are doing ours, but it can, in certain circumstances, cause infection.

Characteristically, I mean, neonatal sepsis in a general sense is characteristically a severe disease that has often a fairly rapid presentation and onset, and among the pathogens that can cause neonatal sepsis and infection, E. coli and other gram negative bacteria tend to be the worst.

So the clinical course can be somewhat variable, but it's not unusual for babies to appear generally well up to a certain point and then rapidly decompensate and for the disease to progress in a very severe fashion thereafter.

Part of that is due to the infection itself. Part of that is due to the body attempting to fight the infection, and as the bacteria are destroyed, they release powerful compounds that cause an inflammatory or sepsis-type response that is often devastating for the body, results in shock, organ failure, et cetera.

In the neonate, the disease can spread rapidly throughout the body and affect essentially all of the major organs. Typically infection that begins right around or the time of birth, for whatever reason, it usually spares the brain and central nervous system, but anything is possible, but liver failure, cardiac failure, bronchopneumonia with respiratory failure are all components of the disease.

Q. In this particular case, we've heard testimony and evidence that this baby, when she was first born, was healthy, Apgar score of eight, normal assessment, comes to the nursery at 7:00. Has normal vital signs at 7:00, and then at 7:25, things begin.

Is that kind of the typical course?

A. Unfortunately, that's a course that commonly occurs within the babies that get this disease and, you know, where a baby

who was well, well-appearing 30 or 45 minutes earlier, starts to show symptoms and rapidly progresses from there.

Q. We've had discussion with other physicians, and I think I had asked the question is it the situation that the baby compensates for a certain period of time and then essentially falls off a cliff? Is that what happens?

A. Yeah. I think that's, in essence, what happens. I mean, particularly with this bacteria and the release of various chemical compounds from the bacteria themselves as well as the tissues in the body that are fighting the infection.

You can develop a situation where the patient is in what's called warm shock, so their blood vessels are becoming more dilated because of these chemical compounds, and initially, when they are able to compensate for that and maintain their blood pressure, sometimes patients actually look extra good. Sometimes people will comment that they actually look pinker than the next baby down, but as that process continues, they reach a level where they are unable to support their blood pressure, perfuse their organs and basically everything falls apart.

Q. I'd like to talk now about Kendall's care, and the jury has been over this. I don't mean to be boring, and we'll move through this quickly. We've seen the initial Apgar scores. I'm going to put that up again here so you have reference. It's 1115. And up in the corner there, without going through

them and discussing them, these are the five minute Apgar scores. Is that a good Apgar score?
A. Yes, it is.
Q. Does that indicate a healthy baby?
A. Yes.
Q. Before we talk a little bit more about that, let me ask you this question: During the course of Kendall's delivery, Dr. Dumpe ended up using a vacuum extractor because of maternal exhaustion. Is that unusual?
A. I don't think it's unusual.
Q. Does that require a pediatrician to be present?
A. I think, again, it's at the discretion of the obstetrician in terms of what they think is going on and how much effort is going to be required.
Q. We've heard that Dr. Dumpe did the McRoberts Maneuver to prophylactically prevent shoulder dystocia. Does that require a pediatrician to be present?
A. I don't think so. I mean, I'm not an obstetrician so I'm not sure I can fully comment on it, but I mean, shoulder dystocia is a bad thing, and that would require a pediatrician to be present.
Q. If it occurred?
A. Lack of shoulder dystocia wouldn't.
Q. In this case, from your review of the record, was there a shoulder dystocia?

A. No, not that I could find.
Q. So putting those altogether, this baby during delivery had meconium, vacuum extractor, the prophylactic maneuver to prevent a shoulder dystocia, was there any reason that a pediatrician should have been present at that time?
A. I don't see any reason why it was necessarily required, you know, and again, I think it would be at the discretion of the obstetrician.
Q. And in terms of what happened afterwards when the baby was born and the Apgars were assigned, that eight, that's a healthy baby; is that correct?
A. Yeah. To me, that indicates the baby appears to be transitioning well and to be in the normal range.
Q. And if we look at the bottom left-hand corner of that, this is Nurse Hendershot's assessment. Again, anything abnormal there that would require the attendance of a pediatrician?
A. No. Nothing is indicated as abnormal. The only notation is that she, I guess, didn't look at the anus, but that's not abnormal.
Q. In terms then of the picture at this point in time, this is 5:20 at the time of delivery, first and foremost, is there any reason that a pediatrician should have been called by the nursing staff at that time?
A. No.

Q. Is there any reason at 5:20, based upon this assessment, that this baby needed to immediately be sent over to the nursery?
A. No, not in my opinion.
Q. Is there any reason at 5:20, based upon this assessment, that she shouldn't be allowed to go -- to stay in the delivery room with mom and dad and bond?
A. I could see no reason for that.
Q. Now, we have heard some testimony about earlier administration of antibiotics. Given this picture here, is there any reason to give antibiotics at that time?
A. No. They are -- certainly not given this picture or the known data that was available at the delivery.
Q. Is there any reason at this point, given her condition, to suspect that she was going to go on and have this overwhelming E. coli sepsis?
A. Unfortunately, there isn't.
Q. And again, is that consistent with what you see with babies who have this type of infection?
A. Yes.
Q. I would like you to assume that Nurse Hendershot has testified here that, per her documentation and chart -- have you had a chance to see her notes of her evaluation of Carissa?
A. Yes.

Q. That she was in to assess Carissa every 15 minutes, and during the assessment process, although not doing a full assessment like was done here, she would have observed the baby, and had anything unusual been occurring, she would have taken the baby to the nursery or she would have alerted a pediatrician, that type of thing.

Is that the normal protocol? Is that what generally happens?

A. Yeah. I tell you that's entirely the standard approach, so nothing unusual about that.

Q. And would you expect a nurse who is NPR --

A. NRP.

Q. -- NRP certified, has 31 years of experience, to be able to recognize if there were abnormalities?

A. Yes.

Q. And if a baby is grunting, flaring and retracting, is that something that a nurse trained like that would be able to recognize?

A. She should be.

Q. Now, we know that this baby was brought to the nursery sometime between 6:50 and 7:00 a.m. What I want to ask you about is the vital signs. Let's put those up there, and I believe that was 1165. If we can just highlight that top section. The jury has seen this before, but these are the vital signs that were taken at 7:00 a.m.

Is there anything at all abnormal with these vital signs?
A. No, not that I can see.
Q. And are these vital signs consistent at that time with a healthy baby with no evidence of infection going on?
A. Yes, they are.
Q. There has been some suggestion here that, had vital signs been taken or an assessment been done at 6:00 or 6:15 or 6:30 or 6:45, any of those times, that somehow something would have been noticed here that would have been abnormal that could have been acted on.
Given the fact that the vital signs at 7:00 were normal, does that make any sense?
A. It doesn't to me. I mean, since we know what subsequently happened, this is a progressive disease, so it's hard for me to imagine that vital signs would be abnormal and then normal. I would expect, if they were abnormal earlier, that they would continue to be abnormal or get worse.
Q. These vital signs that were taken were perfectly normal, correct?
A. Yeah. I mean, there's nothing in them that would raise a concern.
Q. We've also heard testimony in this case that prior to the baby being brought to the nursery that the baby was crying, and I think some of the testimony was she was inconsolable, she was crying, that type of thing.

Is that a sign of infection?

A. I mean, not typically. I mean, it's hard to know exactly what that means. I mean, many babies will cry in the initial period after birth, but crying, in and of itself -- I mean, it's more typical for a baby with infection to be less active, but again, that's highly variable, so I don't know, in and of itself, what can be made of that report.

Q. So based upon these vital signs and your testimony that if they are normal at 7:00, they were probably normal at 6:00, 6:15, 6:30, 6:45, up through this time, is there any reason to suspect that there's infection for which further intervention should have been done?

A. I don't see any.

Q. Now, we know from the record, and the jury has seen this numerous times now, that at around 7:25, 7:20, 7:25, Jamie McCrory noted that this baby was dusky, and there's some question about what else she noted, whether there were breathing difficulties or whatever.

Based upon your review of the record, is that the very first time that you see anything that would indicate that there might be something going on here?

A. Yes. From the record, that's the first time.

Q. And let's put up Jamie's note, and that's 1167 and then put 1172. We looked at this before side by side. What I want to ask you about is the signs and symptoms at this time. Can

you just generally talk about what they were?

MR. PRICE: Your Honor, may I object?

THE COURT: Sidebar.

(At sidebar.)

THE COURT: Mr. Price?

MR. PRICE: Your Honor, these are literally the same questions that were asked of the first expert. Under Rule 403, you have a discretion to limit testimony based upon cumulative evidence, undue delay and a waste of the jury's time, and while Ms. Koczan has the right to bore this jury to death, I think that at some point, cumulative evidence has to be stopped and real questions of different experts have to be asked.

THE COURT: Ms. Koczan?

MS. KOCZAN: Your Honor, I just wanted him to talk about what he saw and what the evidence was and I'm going to be asking him opinions about that. He's entitled to give his opinions about that, but he has to be able to articulate what it was.

THE COURT: He has to be able to provide a foundation what in the record is important to him, but there's a lot of cumulative testimony, and I can see it's wearing on this jury.

MS. KOCZAN: I'll move it along.

(In open court.)

Q. Doctor, you have had a chance to look at those records.

We put them up. You saw what the signs and symptoms were at that time?

A. Yeah. Let me just orient myself. So this is her note at 7:25.

Q. 7:25 a.m.

A. And I think several things are abnormal there. I think, first of all, there's the place where the marker is that notes that the baby is grunting, flaring and retracting, so has an abnormal respiratory pattern, and quite typically in newborns, those are -- some subset of those three phenomenon is what you see.

Grunting, which is just what it sounds like, expiring against sort of a closed glottis, so that type of noise (demonstrating), flaring, which is nasal flaring which newborns do ostensibly to try to increase airflow, and retractions are just that the muscles between and around the ribs are pulling in, whereas normally, when they expand outward, and all three of which indicate some difficulty in breathing.

Q. Now, we know the jury has already seen and heard that when Jamie went in and assessed Kendall, she put a pulse ox on, that it was 81 percent and she placed the baby under an oxy hood. Were those all appropriate interventions?

A. Yes, they were.

Q. And in addition to that, she also called the resident,

Dr. Heiple. Was that an appropriate intervention?
A. Yes.
Q. And the jury has already heard Dr. Heiple testify about what he did when he came in and what his assessment was. I don't want to go over that again, but his actions -- and I wanted to ask you about this. I'd like you to assume that he testified that, when he assessed the baby, her O2 sat was now up to 94 percent, that she was looking okay at that moment and that he did not call Dr. Jones at that point because he knew that she would be in very shortly and she would be assessing the baby.
In your opinion, were his actions at that time appropriate?
A. Yes.
Q. Did they in any way deviate from the standard of care?
A. Not that I can see. I mean, I think particularly, since he specifically knew that the physician was en route, so I mean, I don't know how it would have changed things to notify her a few minutes earlier. She was already on her way there, and that sounds like something fairly standard.
Q. And at that point, was it also reasonable for him to allow her to assess the baby and make determinations about additional interventions?
A. Yeah, because, I mean, she arrived shortly thereafter, yes.

Q. And, Doctor, at that moment in time, do you have an opinion as to whether Dr. Heiple should have ordered antibiotics or anything like that at that point?
A. I think he would have typically waited for the attending physician, knowing that it was going to be a few minutes difference.
Q. I would like you to further assume that when Dr. Jones got there, she ordered, and you saw her deposition, she ordered a variety of things, including antibiotics. Again, were her actions appropriate?
A. They sure look appropriate to me.
Q. And was it appropriate for her to have ordered the transfer of this baby under the circumstances?
A. Yes.
Q. Now, we've heard a lot about the antibiotic administration. I want to ask you some questions about that. There has been testimony in this case that the orders were entered by Dr. Heiple at 8:30 although Dr. Jones had previously been given -- had given a verbal order earlier than that, and that the antibiotics, first and foremost, were ampicillin and gentamicin.
Let me begin by asking you this: Were those appropriate antibiotics to order under the circumstances?
A. Yes, they were completely correct.
Q. And why are those the appropriate antibiotics?

A. Well, again, as I sort of alluded to earlier, there are a number of organisms that are the more common causes of sepsis in the newborn, so worrying about infection immediately after birth in the United States, we typically worry about a group B strep, E. coli and, to some extent, listeriosis, which is a less common bacteria, and so we start with the empiric cocktail of ampicillin and gentamicin, because it generally is effective against those three organisms as well as many others, but it's primarily to treat those three or if one of them turns out to be present.

Q. And in the hospital setting such as this, when you order an antibiotic, is it immediately available for you to give generally?

A. No.

Q. Why is that?

A. Well, that used to be the practice. I mean, fairly quickly available, in that antibiotics were stored on the floor, and depending on the hospital, nurses would draw them up, but I think -- I'm sure actually that the standard practice in hospitals across the United States is that the antibiotics are made up by the pharmacy in the appropriate dose because of appropriate concerns about safety of drawing up the antibiotics, measuring the correct dose, ensuring that they're placed in syringes in the proper way, et cetera, so all of that unfortunately takes some time to get the

antibiotics from the pharmacy, and in my experience, it's typically on the order of an hour to an hour and a half sometimes before antibiotics are given.

Q. In this case, we know that the ampicillin was administered sometime after 9:00 a.m. In your opinion, was that timing in any way inappropriate?

A. No. I think that's pretty standard.

Q. And we've also heard that they did not administer the ampicillin and gentamicin at the same time. Again, is that in any way unusual?

A. No. I think that's the only way you can do it. I think you can't give them both, and you would have to ask a pharmacist exactly why this is a bad idea or the nurse, in terms of flow rates on pumps and things like that, so they are always given sequentially.

In my experience, for whatever reason, most commonly the ampicillin is given first.

Q. Why is that?

A. Well, I think the bugs that you are most worried about are usually sensitive to ampicillin, and that would be group B strep, and virtually all or most of community acquired E. coli, but like I say, you have to give both and you have to give them sequentially.

Q. And, Doctor, the ampicillin, is that something that the nurse can just inject immediately, or does it have to infuse

via IV over a period of time?
A. Yeah. It has to infuse.
Q. And typically, how long does that have to take?
A. I think ampicillin goes in over 30 to 45 minutes.
Q. So if this ampicillin was hung somewhere shortly after 9:00, it would have been like 9:30, 9:40 before you could start the next one?
A. That's what I would expect.
Q. If it was 9:10, it would have been 9:50, something like that?
A. Yeah.
Q. Then gentamicin would have been hung. Again, is that appropriate that it was hung somewhere around 9:50 in this case?
A. Yes, to follow the ampicillin.
Q. There has been some suggestion that because the gentamicin wasn't hung until 9:50, it was somehow delayed and a deviation from the standard of care. Do you agree with that?
A. No, for basically the same reason. I mean, they are both important. They have to be given sequentially, so you have to give one, then the other.
Q. And we've seen some lab work in this case. I'm not going to put it up, but one of the things we saw was the neutrophil count was three percent.
What does that tell you about the extent and duration of

this infection?
A. Well, to me, it says the infection is clearly already well established and likely had been going on for several hours to some extent, if not longer, and that at least at that point, it suggests that the baby's ability to mount a response to the infection was failing.
Q. And I'm not going to ask you to go through the resuscitation. I think the many other doctors that have testified have talked about that, but was or were the events that occurred during the resuscitation again consistent with the clinical course of an overwhelming E. coli sepsis?
A. Yeah, and I mean, I think not only were the actions appropriate, but they considered even somewhat outlying possibilities, including whether the administration of surfactant might improve the baby's pulmonary status, because the infection can interfere with the function of surfactant, and then initiating inhaled nitric oxide because of concern about persistent pulmonary hypertension, so it appears that everything that was possible was done, at a minimum.
Q. And, Doctor, there has been a major issue in this case about whether earlier administration of antibiotics would have made any difference. In your opinion, if they had given antibiotics at 6:30, would it have made any difference here?
A. Well, no, I don't think so. I mean, I pause because I can't think of any indication to give them then, but I think

at that point, the infection was already developing. It's hard to say that there's any likelihood that that much of a difference in the antibiotics would have made a difference.

Q. We've heard questions about, well, we don't know what was happening at 6:30 because there was no documentation, but does that 7:00 a.m. vital signs give you some clue as to what was going on?

A. Well, it does, you know, for the reasons that I think I already mentioned. This is a progressive disease. It gets worse, and so if the vitals were normal at 7:00 a.m., it's hard for me to imagine that they would have been overly abnormal at 6:30.

Q. Prior to the events of 7:25 a.m., was there any reason to give antibiotics or to consider it?

A. Not that I could see.

Q. Would an earlier administration of antibiotics at any time during the course, 6:00, 6:15, 6:30, 6:45, 7:00, 7:30, 8:00, 8:30, would that have made any differences in the outcome in this case, in your opinion?

A. In my opinion, it's very unlikely that it would have made any difference whatsoever.

Q. There has been questions posed to one of the other experts about a chance. Was there any chance? In your opinion, based upon what you saw, was there any chance for a different outcome in this case, given this child's E. coli sepsis?

A. Well, not given -- in my opinion, not given the way -- given the way that the case unfolded where there was no marker that would prompt earlier evaluation and administration of antibiotics, I can't see where there was an opportunity to change the outcome, so no.

Q. One other question I wanted to ask you about is meconium. Based on your review of these records, do you believe that meconium and the aspiration of meconium played any role in the clinical course here?

A. It's hard to say it played no role whatsoever, because we know that there was some evidence of meconium being present in the lungs, but meconium aspiration is usually evident by respiratory distress soon after birth, so the absence of respiratory distress early on would, in my opinion, argue very strongly against meconium being a significant factor, if any.

Q. Doctor, just one final series of questions. There has been testimony in this case about the Heritage Valley policies and procedures.

Based upon your review of the policies and procedures, do you believe that they are in keeping with the standard of care for such policies and procedures?

A. In my opinion, they are in keeping with the standard of care. I mean, there's -- I think different institutions do things differently and that's fine, but in terms of sort of the basic standard of care, I didn't see anything in these

policies that stood out as a deviation from that.
Q. And have all the opinions that you've rendered here this morning been rendered within a reasonable degree of medical certainty?
A. They have.
MS. KOCZAN: Thank you. That's all the questions I have for you.
THE COURT: Mr. Colville, any questions of this witness?
MR. COLVILLE: No, Your Honor.
THE COURT: Mr. Price?
MR. PRICE: Sure.

CROSS-EXAMINATION

BY MR. PRICE:
Q. Doctor, shoulder dystocia, you said that if a shoulder dystocia occurs, a pediatrician must be present at delivery, correct?
A. Well, I think typically, a pediatrician or somebody would be requested. I mean, if it occurs, I mean, most hospitals where babies are being born, there may not be a pediatrician there so they may arrive well after the birth, but typically it would be an indication to request a pediatrician.
Q. Typically, in shoulder dystocia cases, a McRoberts Maneuver is done, correct?
A. I don't know what's typical.

Q. Tab 2, page 2. This is the coding summary, and as you'll see, the last issue is shoulder dystocia that was billed for this procedure. So you would agree with me that, if Dr. Dumpe billed for a procedure involving a shoulder dystocia, that a pediatrician must have been present at delivery, correct?

A. No. In my experience, I don't know -- I don't think -- I think he has no choice but to code it that way, but I really don't know, so -- I don't know that coding -- this coding indicates that there was a shoulder dystocia. His testimony is that there wasn't, so I don't think I can say anything more than that.

Q. Well, as a doctor, you are only allowed to bill for the procedures that you perform, correct?

A. Well, that's true, but oftentimes in identifying a code, you have to take a code that relates to what you are doing, so I mean, I don't think that there's an exact -- I'm quite sure that there's not an exact correlation between billing codes and what happens clinically, so that's about all I can say about that. This is a billing code.

Q. We'll leave it at that. Can you go to the PowerPoint? Now, I am going to ask you a pretty long hypothetical. This delivery, you had a delivery where the fetal strips were a category two plus. Do you agree with that?

A. I don't really interpret the fetal monitoring strips, but I think that's how they were interpreted.

Q. There was an arrest of descent and operative delivery in this case, correct?
A. That's right.
Q. There was a shoulder dystocia and McRoberts Maneuver, correct?
A. Again, I don't know that there was a shoulder dystocia. I think there was a McRoberts Maneuver.
Q. And there was meconium present?
A. That's right.
Q. With all of these risk factors, it's your opinion that a pediatrician did not need to attend this delivery?
A. No, I don't -- I don't know that it was necessary. I don't think it would have been unreasonable. I don't know that it's necessary.
Q. And this baby needed resuscitation with both bulb suctions and deep suctions, correct?
A. Yes.
Q. Okay. I'm going to ask you this hypothetical, because you have been called in deliveries like this before, correct?
A. Sure.
Q. After being called to deliveries like this, you make plans of care for babies, don't you?
A. Depends on the circumstances, yeah.
Q. And a lot of times -- this would be a typical type of order. I want you to assume that an order is being made to

monitor the baby every 15 minutes, and to monitor the baby would include two things: Vital signs be taken and a pulse ox. Okay?

A. If that's what the standards were in the hospital. I think it varies from hospital to hospital.

Q. But you have done plans of care like this before where you said, hey, nurse, just monitor every 15 minutes for vital signs or a pulse ox, correct, or and a pulse ox?

A. I suppose so. I think if it's a well-appearing baby, I wouldn't specify.

Q. Okay. Well, I am asking you to assume that a plan of care is set up that the baby is monitored every 15 minutes which includes vital signs and pulse ox, okay?

A. Okay.

Q. Fifteen minutes later, family is enjoying the baby, the baby is crying excessively, there's grunting seen. An exam is done which shows the pulse ox is a little bit low, okay.

A. Okay. So this is a hypothetical?

Q. Correct.

A. Okay.

Q. Thirty minutes after birth, more family are in. They are enjoying the baby, but the baby is still crying excessively. At this point, grunting is noted as well as a witness says flaring and the pulse ox is dropping. Do you agree?

A. Well, there's nothing for me to agree with.

Q. That's my hypothetical.
A. I understand what you are asking, what you are painting a picture of, sure.
Q. Forty-five minutes after birth, this baby is still crying. The family is reporting that the baby seems to be in pain, still grunting and flaring and the pulse ox is still dropping. Okay?
A. I guess I have no idea what "still dropping" means.
Q. The pulse ox is dropping from normal.
A. Progressively?
Q. Progressively.
A. So now it's been 45 minutes?
Q. Right.
A. I mean, what's it dropped to?
Q. We'll find out in a minute. At one hour, do you believe a pediatrician, in a situation like that, should examine the baby?
A. I mean, in a hypothetical situation like that, my expectation would be that, you know, a pediatrician -- some pediatrician might examine the baby, or a nurse, yeah.
Q. You would also believe that a pediatrician, under this hypothetical examining a baby, might find signs of respiratory distress, correct?
A. Well, the hypothetical you've painted describes respiratory distress.

Q. Correct.
A. So, yes.
Q. And under a situation where you find a baby in respiratory distress, the first thing that you do is provide supplemental oxygen, and the second thing that you do is a neonatal sepsis workup which includes providing antibiotics, correct?
A. Not -- no. I mean, the first thing you do is assess the baby, and that would probably, if you had a pulse oximeter on the baby and it was below the normal range, you would typically give supplemental oxygen, but then you would make a decision about what to do next.
Q. Can you pull that down for one second and pull up tab 6, page 60? Now, we have seen this ad nauseam, but sometimes as you are traveling through these cases, you find something new and you want to point it out.
So if you could just do the 7:00 and the 7:25 vitals so the jury can see both of them, because what we have been told all along is that, hey, at 7:00, these vitals are normal. That means this baby was healthy, correct?
A. Yeah. I mean, it appeared healthy, yes.
Q. Tell me at 7:00, what was this baby's pulse ox?
A. There was no reason to measure it.
Q. No, that's not the question. The question is at 7:00, what was the baby's pulse ox?
A. It wasn't measured.

Q. Don't know, correct?
A. (Witness nods head affirmatively.)
Q. Let's take a look at the temperature at 7:00 was 99.6. At 7:25, it had dropped to 99.2, so it's still the same, right?
A. Essentially.
Q. The temperature degrees -- well, it's just Celsius and Fahrenheit. The next one, heart rate 132 beats per minute. Heart rate is 128, correct?
A. Yeah.
Q. Same thing basically, right?
A. That's right.
Q. The respiratory rate is noted at 44 beats per minute, but it's not calculated here, but here is the outlier, correct?
A. I'm not sure I know what you mean by the term "outlier."
Q. The outlier is you have normal vitals at 7:00, you have normal vitals at 7:25, and the only thing that's different is the 81 percent, correct?
A. Yeah, that's true.
Q. So my point is is that by looking at the vitals at 7:00, we have no clue whatsoever what this baby's respiratory status is, do we?
A. Well, no, I don't think that's correct. I mean, the respiratory rate is normal, and the baby is being looked at, so there's no evidence that the baby has anything abnormal.
Q. At 7:25 -- let me back up. The reason I asked you all

this was, you'll agree with me that, in a case where a baby has meconium in its air sacs, that the baby might not be processing air as efficiently as one that doesn't have meconium, correct?

A. If in fact they have aspirated meconium, that might be true.

Q. Right. And that could account for the reason why a pulse ox is low, correct?

A. It could be one of the reasons, sure.

Q. Right. And we know at 7:25 that the pulse ox was 81, correct?

A. That's what was recorded, yes.

Q. And we have no idea what the pulse ox was for the two hours before that, correct?

A. Well, it wasn't measured.

Q. So we don't know?

A. Sure, but are you suggesting that every baby should have -- that the only appropriate thing is that every baby has continuous pulse oximetry monitoring from the moment of birth despite looking well? It's an interesting thought, but it not only doesn't happen, but it's generally recommended against.

Q. I didn't say that in my hypothetical. I said with all of the risk factors, with the fact that there was meconium present, with the fact that this was a difficult operative delivery, that there was an arrest of descent, that a

pediatrician who had come to the delivery, set out a plan of care and said get vitals and a pulse ox every 15 minutes might have picked up on this before two hours. Would you agree with that?

A. If that's what their decision had been, sure, but I don't think that would have been a routine decision in an apparently healthy-appearing baby after this delivery.

MR. PRICE: Your Honor, I'm sorry. I should only be about two more minutes.

THE COURT: Ladies and gentlemen --

MR. PRICE: I'd like to finish if that's all right with the jury.

THE COURT: Yes. I was just going to ask them that. Ladies and gentlemen of the jury, as you know, we're going to recess early today because of the swearing in ceremony. Would you mind if we go a little bit past 12:00 to finish up this witness? Everyone is indicating they are okay. Anybody need a necessary break or anything like that? Everybody is good to go. Mr. Price, you can continue.

MR. PRICE: Thank you. I just wanted to finish up with your final answers to Ms. Koczan about antibiotic administration.

BY MR. PRICE:

Q. Under my scenario, if a pediatrician had seen this baby at one hour and given antibiotics, was there a chance that this

baby could have been saved?
A. So at one hour versus three hours? I think it's extremely unlikely.
Q. I know. You keep saying very unlikely, extremely unlikely, but in your report, do you ever put that that would not happen, that the baby would not have survived? You condition -- in other words, you can't exclude the possibility, right?
A. I don't think I can ever exclude any possibility, but other than that, I would say, in my opinion, it's extremely unlikely unfortunately that it would have made a difference.
Q. And you said there is a chance -- or there is not a chance given the way this case unfolded, and that was based upon the facts that Ms. Koczan gave you, correct?
A. Well, I think it's the facts that, unlike the hypothetical, it's the facts in this case.
Q. Well, see that's what the jury's job is. The jury is going to determine the facts of this case.
So you'll agree with me that, if the facts unfolded differently as I mentioned, earlier administration of antibiotics would have given this baby a chance at survival?
A. Well, again, it's an indeterminant statement, because what does "earlier" mean? But I think if the case -- I mean, it's all hypothetical. If the case had unfolded as you presented it, with the baby having evidence of significant respiratory

distress earlier, again, knowing that this ultimately turned out to be E. coli sepsis, I would say, well, that would be evidence that the disease was already more severe at 6:30 or 6:00 or wherever these times are in your hypothetical, and frankly, I think that probably would have made the chances of survival -- I mean, I don't think they could have been lower, but there's no way they would have been improved if the baby had been ill already at that time.

MR. PRICE: No further questions.

THE COURT: Ms. Koczan, any redirect?

MS. KOCZAN: Just one or two, Your Honor. That's all. I will be quick.

REDIRECT EXAMINATION

BY MS. KOCZAN:

Q. Doctor, you were given -- shown hypotheticals, pulse ox dropping, this happening, that. Is there anything in the record that indicates that any of that went on?

A. No.

Q. Does the medical record indicate then that the very first time that there was anything going on with this baby was at 7:25 a.m.?

A. Yes, it does.

Q. And just one final comment. Earlier administration, would that have made any difference in this case?

A. No.

MS. KOCZAN: Thank you.

THE COURT: Mr. Colville, at this time?

MR. COLVILLE: No, Your Honor.

THE COURT: Mr. Price, anything further?

MR. PRICE: No, Your Honor.

THE COURT: May Dr. Ringer then step down and may he be excused?

MS. KOCZAN: Yes.

THE COURT: He's ready to go. Doctor, safe travels. Thank you for your appearance here today. You may step down. You are also excused.

(Witness excused.)

THE COURT: At this time, does the defendant hospital group and Dr. Jones rest?

MS. KOCZAN: We do, Your Honor.

THE COURT: Mr. Colville, does the United States also rest?

MR. COLVILLE: We do, Your Honor.

THE COURT: Any rebuttal, Mr. Price?

MR. PRICE: No, Your Honor.

THE COURT: All right. Ladies and gentlemen, for your information at this stage of the proceedings, the court will have to address various legal matters with the attorneys, particularly working on the charge to the jury, and I would anticipate that we'll get that done this afternoon, so

tomorrow's schedule should be closing arguments, correct?

So we'll start tomorrow at 9:00 with closing arguments, and then you'll hear the charge to the jury and then the case will be yours.

Now, as I indicated previously, the court has a swearing in to attend to and I have to report between 2:30 and 2:45 for that. I'm expecting what we need to do with the attorneys on the legal front is going to take that time after a short lunch break, so I'm going to give you the rest of the afternoon off. It looks like a pretty day again.

I want to remind you not to discuss this case with anyone, including fellow jurors, other people involved in the trial, members of your family, anyone else. Again, as you leave, do not speak to any of the parties, witnesses or others who have been gathered here, similarly, when you come in first thing tomorrow.

Once again, I don't know if there is or isn't news coverage about this matter. If there is, obviously you need to avoid it. Once again, even though you've heard all of the evidence that we anticipate in this case, you are not to do any research or gather any information on your own. Continue to keep an open mind about what the verdict should be in this case because you need to hear from the court and you also need to hear from the attorneys, first the attorneys with their closing arguments, then the court with its instructions and

how you'll fill out the verdict form.

Then and at that time, you'll have all the time you want to debate the issues, to go through your exhibit binders and ultimately first find the facts and then apply the law.

So with that, have a good afternoon and evening. We'll see you all back here tomorrow at 9:00. Mr. Galovich will escort all of you. Once again, leave your exhibit binders as well as your notepads there on your chairs. He'll gather them up.

(Jury excused.)

THE COURT: Everybody may be seated. And so I would suggest that we take a lunch break, and given the fact of the jury being recessed, do you all think you can be back here at 1:15, and at that point, we'll address what I anticipate will be Ms. Koczan's motion on corporate negligence and the plaintiff response, and we'll also take a look at the instructions so we can try to get those finalized, and then as I said, we're going to wrap up between 2:30 and quarter to 3:00 because I have to have my robes on and be in another court by quarter to 3:00. We'll see you back here at 1:15.

(Luncheon recess taken 12:09 p.m.-1:19 p.m.)

THE COURT: I think first we should have argument on the Rule 50 motion. Ms. Koczan?

MS. KOCZAN: Yes. Your Honor, we are bringing this Rule 50 motion with regard to the corporate negligence claim

against Heritage Valley, and the basis for the motion as set forth in our brief is that there has been no expert testimony to establish that the hospital in any way deviated from the standard of care, as required under the various elements of the Thompson versus Nason Hospital case, and in this case, the only really portion of that was -- I think it's number four which is the hospital's policies and procedures.

Earlier, there were cases that were cited that, and I think Your Honor had mentioned them, that said you don't have to have an expert to give the opinion if it's within the knowledge and understanding of the jury, but that's not the situation here, and I think that those cases, as we set forth in the brief, can be distinguished, both the Cangemi cases and I think it's the McKay case is the other one, and those cases involve things like, you know, did you need to have expert testimony to say that it would be imperative to make sure that you got the radiology reports to the physician, that type of thing. That's within the average knowledge of a juror.

This case is really very different and can be distinguished because it isn't within the average knowledge of a juror as to what a policy should be with regard to pediatrician attendance at a delivery, you know, the circumstances of that, so under those circumstances, the case law is pretty clear that you do require expert testimony, and to that end, there has been no expert testimony in this case

that the policies deviated from the accepted standard of care.

The expert who talked about this, I believe, was primarily Dr. Karotkin or it could have been Dr. Shore, I'm getting them mixed up right now, but what they basically testified to was that at their hospital, they did something different. Their hospital required something different. He didn't agree with the policy, but at no time did he say that the policy that Heritage Valley had deviated from the standard of care, so there is absence of any testimony here that there was any deviation from the standard of care, and again, that would have been required -- or, that is required to go forward with the corporate negligence case.

So under the circumstances, I do not believe that there is any evidence in this case of deviation that meets the requirement, and on that basis, I believe that the Rule 50 motion should be granted.

THE COURT: Mr. Price, your response?

MR. PRICE: Twofold, Your Honor. I rely upon my response to Defendant Heritage Valley Beaver's motion in limine with regard to this issue to begin with, because I believe that a corporate negligence claim is not limited solely to policies and procedures, so I believe that there are still other issues which allow this claim to survive.

Secondarily, as to this specific issue of policies and procedures, Dr. Karotkin did testify about the policies,

that they were incorrect and that it did affect the care and that it was a breach in the standard of care, and I note in this court's memorandum order of August 30, document 195 on page 5, the court specifically noted Dr. Karotkin was critical of some of the hospital's policies and testified that they negatively impacted Kendall's chance of survival, and I don't believe that the defendants putting Dr. Dumpe on or having their own experts removed this issue from the jury's contention.

As the standard was noted in the court's previous ruling as to Dr. Jones, any dispute, any contention as to documents or testimony is for the jury to decide.

THE COURT: Anything further, Ms. Koczan?

MS. KOCZAN: Yes, Your Honor. I'm not sure what other issues there are under the corporate negligence. I don't remember hearing anything, any other issues with regard to that. It's really coming down to the policies, and what Mr. Price cited was your ruling before this case even was tried. You know, there was no testimony. It was simply what was written in the report, and what was written in the report isn't evidence in this courtroom; it is his testimony, and while he said this is not what we do at my institution and I don't agree with it, he didn't say that it deviated from the standard of care, and I think that's the important distinction here, and I do not believe there is any other evidence that

would support a case for corporate negligence.

THE COURT: Anything else?

MR. PRICE: Just to correct Ms. Koczan, I cited to your memorandum order of August 30. It was document 195 and it was -- it notes, "And now this 30th day of August 2019, upon consideration of the motion for directed verdict filed pursuant to Federal Rule 50," so Dr. Karotkin had testified and you did consider it in making that ruling.

MS. KOCZAN: Your Honor, you haven't considered the Rule 50 motion for corporate negligence before so I'm not sure what he's referring to.

THE COURT: All right. Well, the court has had the benefit, as you know, of the expert reports as well as the curriculum vitae, but in looking at this motion for directed verdict, I always think too it's important to look back at the initial pleadings here, and to that end, vis-a-vis this corporate negligence claim, Mr. Price has alleged that the defendant, the hospital, was negligent and a number of particulars.

I particularly call your attention to paragraph 126 and the subparagraphs thereunder, and to that end, one of the subparagraphs speaks to, "In failing to ensure the physicians, medical staff, nursing staff and/or other health care providers were properly trained to recognize signs and symptoms of nonreassuring fetal heart tones and/or fetal

distress."

Then in that same paragraph, it also talks about "Failure to ensure that the health care providers were not only properly trained but adequately staffed to take timely action."

There's some further allegations about selection, retention and employment, then it goes on to talk about failing to ensure that health care providers were properly trained on how to document the medical records.

There's also an allegation here about failing to properly train, supervise and/or oversee health care providers in promptly and accurately communicating a patient's status to treating physicians and/or health care providers.

Then it also speaks to the policies and procedures at subparagraphs K, L, M, and N as well as O and P, Q and ultimately S, and then it also talks about delegation of responsibilities.

So as pled, the allegations are much broader than, number one, the promulgation of policies and/or two, the adherence to those policies.

The court is also certainly mindful of what I already wrote at document 187 and the cases to which I cited, and I also took the time to read the cases that Ms. Koczan has provided in her latest memorandum, much of which mirror what I've seen previously, and to that end, the only difference I

see is the Macosky, M-A-C-O-S-K-Y, versus Udoshi case which she spends a little bit more time on trying to factually distinguish it.

But more recently, one of my colleagues in the middle district has again looked at the issue of corporate negligence, and furthermore, you know, I've also conferred with my colleagues on this issue in cases where they have previously addressed this issue, and I guess, in most instances, the argument is heard and then the motion is simply denied with a lot -- without a lot of rationale, and I guess that's one way of doing things.

But be that as it may, this court has had the benefit not only of her copious notes but also the rough draft transcripts, and pertinent to my decision is the following: First off, Dr. Zamore -- and by the way, you know, all of these witnesses, in my estimation, were all adequately and then some credentialed. Some of them were from some of the top institutions in the country.

I think everybody knows Boston Children's is number one. I think that Philadelphia Children's ranks up there pretty high as well. Vanderbilt was also referenced, and certainly Harvard was thrown around a few times, so we had all the experts with appropriate credentials and the like, but of course, differing views. That's why we have trials.

But in any event, Dr. Zamore initially said that if

the baby is at risk, a pediatrician has to be present. And to that end, he said that he either hands off to the labor nurse or the pediatrician. He also talked about advocating for the patient, that that's a duty of the physician as well as the nurse. He spoke to a standard of care, that the pediatrician should be notified and called into the labor room. When shoulder dystocia is recognized, get a pediatrician.

He also said that meconium throughout the entire labor is also an indication for calling a pediatrician.

He also went on to say if the doctor doesn't do it, then go up the chain of command. That's exactly what Nason speaks to. That's why we have that landmark decision Nason, because the nurses occasionally have to blow the whistle.

So if nurses see issues, they have a responsibility to call the pediatrician into the room. They also have a responsibility to advocate for the patient, says Dr. Zamore.

He then went on to say that Dr. Dumpe deviated from the standard of care when there was no pediatrician in the room when he had an indication of a shoulder dystocia. He had an operative OB delivery, he had category two tracings as well as meconium.

Now, certainly Dr. Dumpe testified to the contrary and he spoke at length about what he described as the continuum of risk, and he also referenced his discretion as an OB, and he did admit though, if the risk was high enough, he'd

even want a pediatrician there or a pediatric designee, and he then went on to say, in some instances, for some babies, he would definitely call a pediatrician.

And the purpose of that person being there would be to respond if there was any respiratory distress. In this instance, he didn't think he had a need to call a pediatrician. Troubling, frankly, to the court and in my estimation cavalier, when he was asked about the policies, and I'm quoting, "I couldn't put my signature on there without my input because I'm the chairman of the department. I'm very friendly with the head nurse. She puts these things together. She bounces these things off me."

Now, when he was called within the hospital's case, and perhaps he was nudged, to be a little bit more thoughtful in how these policies and procedures were promulgated.

He also admitted that he's called pediatricians to the delivery room and he admitted that if there were abnormal Apgars that then someone would be required to call a pediatrician to the nursery. He talked about the baby being able and being able to be transported to the nursery. If not to the nursery, to call residents.

Admittedly, we've heard a lot about this baby bonding, and if the baby is normal, it's appropriate to keep the baby in the room so that the baby can bond. Once again, you know, it was interesting in reading Nurse Hendershot's

testimony that "It was his call," Dr. Dumpe's call, "not mine," to determine whether or not a pediatrician should be called.

And going back to Nason, I don't think it's only his call, and in my estimation, she was deferential to the doctor in that regard, and I don't know what that speaks to, his manner in the operating room, I don't know, you know. She is a long time nurse, 30 years. You know, he's a long time OB. He has a military background. I don't know what goes on in that particular hospital, but I thought that was an interesting comment that she made, "His call, not mine." She said, "I can suggest," but in this instance, she would not have suggested.

I also took a look at the testimony of Dr. Shore. Again, he said if the baby is at risk, the pediatrician must be there, and he also spoke to either a pediatrician or a neonatal specialist such as a NICU nurse. In this particular hospital, they don't have a NICU, right? They have level two nursery, so they don't even have a NICU.

And Dr. Shore said you need to have someone there to evaluate the baby and plan for subsequent care. To that end, he saw the meconium in the amniotic fluid as a risk. It's an abnormality, in his words. He also went on to say that it's actually fearsome if the baby was premature. This baby was term, maybe post term, given its side.

He did not agree with the policy of Heritage Valley. He did say there are hospitals which require people to be there with meconium. He also indicated that the baby's irritability could indicate sepsis or lung pain. He noted that the baby had a small pleural effusion. And to that end, in his estimation, such a pleural effusion hurts the baby. Hence, a pediatrician should have been called.

Jamie McCrory also said something rather curious that stuck in my mind, and to that end, she said, in any event, when the pediatrician is on the way, all the babies come to the nursery for assessment.

So, I mean, a jury could consider that, in that particular instance, given that statement by Nurse McCrory that it was routine, if you will, that this baby ultimately went down to the nursery, because everybody knew that Dr. Jones, who was very punctual, was supposed to be there at 8:00. Hence it was time for the pediatrician to eyeball everybody.

Frankly, I found Dr. Heiple underwhelming, and admittedly, I'm not supposed to critique somebody in terms of credibility, and frankly, you know, he had very limited pediatric training at that point in his career. He's a family resident. He's not a board certified pediatrician. I don't recall if we heard anything about him knowing how to resuscitate a neonate. When he referenced the baby as a case,

that gave me a little further insight into his personality and the way he might be out there practicing medicine.

Dr. Karotkin is certainly key to the plaintiffs' case. He talks both as a pediatrician and neonatologist. Again, he says the delivery should have had a pediatrician in attendance and he reasoned because of the moderate to high risk nature of the mother's circumstances, the meconium, the operative delivery, the concern for the shoulder dystocia and the delay in getting the baby delivered. It's true this lady was in labor for some period of time and then she did not continue to descend. She arrested.

You know, interestingly, when you look at the consent here, she was given an epidural. You know, when you have an epidural, that in and of itself slows things down, and we never heard any discussion by the way of the consent what the doctor did or didn't do with this gal.

But be that as it may, Dr. Karotkin went on to say there's nothing like the experience of board certified pediatricians. He also went on to say that the baby should have been monitored more closely with either a pediatrician or a nurse listening and observing this baby. He did indicate that if you are on call, you should respond within 30 minutes. That's reasonable. He talked about the Reasonable Man Standard as well.

He recalled the perinatal guidelines, and I thought

it was interesting to the extent that the hospital, Dr. Dumpe or anybody else wants to make reference to those ACOG standards or the perinatal standards, how easy would it have been to have a slide to compare them and whether Heritage Valley really does adhere or not, but we didn't see that.

To that end, he went on to say that the call to the pediatrician could have been made either by the OB or by the nurses. He also noted that, in his estimation, the lack of recording was also a breach of care, and he also found that there was a delay in care, that the septic workup would have been faster.

To that end too, he was noteworthy in his recognition of the reports of the family, that the reports of the family do matter. He did go on to say that most hospitals have a different policy, and despite what you said, Ms. Koczan, he does say that this did not meet the standard of care in his testimony.

So to that end, I think that, in and of itself, is enough to put this case over to a jury on the corporate negligence case, but it's also interesting for me to note too that Dr. Ringer said he didn't think it was necessary but it was certainly not unreasonable to have a pediatrician there, and he also said if the hypothetical facts are ultimately true and accepted, that it would have been beneficial to have called a pediatrician or a nurse.

So, you know, whether the jury considers these policies and procedures to be breached or not, whether they consider that this is the standard of care or not, whether they find that the hospital as an institution didn't live up to its duties under Nason and its progeny, then and in that event, I think it's a jury question for the jury.

To that end, I'm going to write a little bit about all this, and I'm going to lay out the cases to which I want to cite and we'll put that on the docket in due course. Of course we have other things to address.

So that's my ruling on corporate negligence, and you know, as I said, given my time constraints, since all of a sudden, we are interested in getting this case done sooner rather than later, that's as far as I got, but I'll continue to plumb the transcript if I need to, although I do think that, based on what I've seen here, that this is sufficient to take this case over to the jury.

Okay. Nicole, print off what you sent me last night on Waugh. I want to add that to the record here too. I didn't finish all of my research. There's a brand new opinion -- relatively new opinion by Judge Mariani out of the middle district. It's only 129 pages long. Of course, it covers all kinds of subjects beyond corporate negligence.

So what's striking here to me is this language: "Corporate negligence is a doctrine under which the hospital

is liable if it fails to uphold the proper standard of care of the patient which is to ensure the patient's safety and well-being while at the hospital."

Here we have two patients, both Carissa as well as Kendall, and indeed this theory of liability creates a nondelegable duty which the hospital owes directly to the patient, both mom and baby.

You know, I'm also mindful of this language which appears in the recent Mariani case, Ponzini. "It's well established that a hospital staff member/employee has a duty to recognize and report abnormalities in the treatment and condition of its patients. If the attending physician fails to act after being informed of such abnormalities, it's then incumbent upon the hospital staff or employee to so advise the hospital authorities so that appropriate action might be taken. When there is a failure to report changes in a patient's condition and/or question a physician's order which is not in accord with standard medical practice and the patient is injured as a result, the hospital will be liable for such negligence.

"Health care providers are deemed to have constructive notice when it should have known of the patient's condition or where there was an absence of supervision," again Ponzini.

So, you know, back to whether a jury can or cannot

discern, you know, whether or not, number one, this policy, discretionary call to the pediatrician by the OB, is or isn't reasonable, I think they have a sufficient basis. They can weigh what all these doctors had to say. They can weigh what the nurses had to say. They can weigh what Dr. Dumpe and Dr. Jones had to say, and then they can make a determination whether there is or isn't corporate negligence on the part of Heritage Valley Beaver.

Okay, now, moving on to the final jury instructions, over the lunch hour, I went back through the draft that was circulated to all of you, and Nicole made changes, and Mr. Kravetz is supposed to be proofing those changes, but in a nutshell, what I did was I went through the discussion draft number five that went out to you on e-mail and to which Mr. Price had no objections and Ms. Koczan had an exception, and we needed to correct the typographical error of for whom Dr. Jones works.

Now, on these edits, what I normally do is I take out the references to whether your proposed instruction came from the PA standard or the Third Circuit and the like. I don't think the jury needs to ponder what treatises we're looking at when we come up with these instructions, so those kinds of things get eliminated throughout.

In addition, and most importantly, I think for all of this, in looking at paragraph 5, I think you know we talk

about stipulations. I shouldn't say paragraph 5. I mean, page 5. In talking about stipulations, we say here that the medical records of Carissa and Kendall are authentic, that at all times relevant, all nurses and doctors and residents were employees, blah-blah-blah, that at all times relevant to this case, Dr. Hilary Jones was an employee of Heritage Valley Pediatrics, but then I think we should go on to say here that there's no claim against Dr. Hilary Jones for her care of Kendall Peronis once she began to administer that care. I believe we should say that.

Additionally, per our discussion yesterday and now that I have Mr. Price's e-mail wherein he writes to me, "Ladies and gentlemen, when Dr. Wiesenfeld, the obstetrical expert for the United States, was on the witness stand, I asked him several questions about a prenatal office visit wherein the doctors diagnosed Ms. Peronis with a bacterial vaginosis. If you recall Dr. Wiesenfeld's testimony, he stated that the bacterial infection was not related in any way to the infection that is at issue in this case. I am instructing you to give no weight or consideration to that bacterial infection, as it is irrelevant to your deliberations in this case."

So I pondered whether we should give this just as it is, but I'm a little concerned that it might highlight the fact that the court asked questions, and to this end, I

believe because I am the finder-of-fact vis-a-vis Dr. Dumpe, from time to time, it was important for me to ask questions so I could determine how credible he is or isn't.

So I rephrased this a bit and what I have here is that there is no claim that the infection Carissa Peronis had while carrying Kendall Peronis had any relation to the E. coli sepsis infection Kendall Peronis developed. In fact, Dr. Wiesenfeld testified that the bacterial infection was not related in any way to the infection at issue.

So that's another change that I made.

Also on page 6, since we had timelines, I've included timelines along with other charts and summaries, and I've made some transitions here so this is not incredibly boring as I read it to them.

In addition, as I noted, I've taken out the references to the various instructions. Again, I've added a couple of transitions because they have been repeatedly instructed on how they are supposed to handle an expert, but when I get to the part about Hilary Jones and who she works for, that needed some more work, and so there, I've rewritten it, "Therefore, if you find the defendant Hilary Jones or the nurses and resident doctor to be liable, then you must find, in the case of Dr. Jones, Heritage Valley Pediatrics and in the case of the nurses and resident, Heritage Valley Beaver Hospital also liable." So that needed to be changed. I saw a

couple of typos that we've corrected.

Relative to the damages, I think given the nature of this case and given we've heard so much about Kendall, I think that we should say in terms of the harm suffered by Kendall Peronis, Carissa Peronis and Matthew Fritzius, I'm debating that and I'll be interested to hear what you have to say on that. We only spoke to the parents initially.

Also, when we wrote this up, we talked about both of the adult plaintiffs being administrators, they are not, and so Carissa is the administratrix and he's there individually so that needed to be changed.

I do permit the headers in terms of past loss contributions, past and future noneconomic damages and the like. Again that's stylistic. We can take that out if you please.

So those are the changes that I've made. Ms. Starr tells me that these have now been proofed, so we are up to discussion draft number six, and she is going to run and get copies so all of you counsel have an opportunity to read these one more time and so that Ms. Leo has a copy for her benefit and Mr. Galovich will get one as court Exhibit A.

We also, by the way, have similar issues vis-a-vis the verdict slip, and that verdict slip, I think, needs to be retyped so that it reflects the relationship, if you will, between Jones and Heritage Valley Pediatrics if they are going

to remain in the case.

MS. KOCZAN: Your Honor, with regard to that, I'm not sure that that needs to be done because I would stipulate that if Jones was found liable, Heritage Valley Pediatrics would be, so I don't think we need to do that.

THE COURT: In terms of the verdict slip?

MS. KOCZAN: Yes, in terms of the verdict slip.

THE COURT: Well, in terms of the instructions then, do we need to make any changes vis-a-vis the instructions? So should we be including that stipulation in here?

MS. KOCZAN: I don't think it's necessary, but you could mold the verdict based upon that. I don't think it's necessary that we have to include a stipulation that it's stipulated that, you know, Jones is liable, Heritage Valley Pediatrics is liable as well. I just think, with my agreement that if the jury finds Dr. Jones liable, then the verdict is molded to include Heritage Valley Pediatrics, that that should be sufficient.

THE COURT: What do you think, Mr. Price?

MR. PRICE: Typically on a verdict slip in a case like this, if we can just leave it to defendant, that's fine for me because I don't think -- I think if you include the employer and all that stuff, it confuses the jury, but I think that the jury should be told that if you find against Dr. Jones, her employer will also be liable, and I know that

somewhere, I was just trying to find where, that is in here.

THE COURT: I will do likewise. The other thing we could do is we could drop a footnote. We've done that in other verdict slips, explaining to the jury that if they find Dr. Jones liable, per the stipulation or agreement among counsel, then and in that event, Heritage Valley Pediatrics is also liable and just drop a footnote.

MS. KOCZAN: Your Honor, I'm waiting for her to bring the revised copy. My copy is in my briefcase, but there's one other thing that I recall seeing the damages, and I didn't include it in my e-mail. I thought there was something in there about like lost household services, this, that and the other. If I remember and I will stand corrected if he did, Dr. Kenkel did not include lost household services in his testimony and in the estimates that he gave. It was just wage loss, so without that testimony, I don't know that that instruction is proper.

THE COURT: Mr. Price, what do you have to say about that?

MR. PRICE: I would have to go back to the --

THE COURT: Before you get there, I have found a section of the charge that deals with the employment situation at 19. "In this case, it's also admitted that the nurses and resident doctor were, at the time of the occurrence, acting as the employees of the defendant Heritage Valley Beaver Hospital

known as the employer and were engaged in furthering the interests, activities, affairs or business of their employer. An employer is liable for the negligence of its employee occurring while the latter was acting in the course and within the scope of his or her employment."

Then it goes on, "Therefore" -- I'm sorry. Even ahead of that, we say, "In this case, it's admitted that defendant Hilary Jones was acting as the agent of defendant Heritage Valley, known as the principal."

So we cover that on page 19 of this draft number five, and then we say that the principal is liable there. We say vis-a-vis the hospital. Then we have a catchall, therefore, if you find that she is liable or the nurses and doctors are liable, then you have to find Heritage Valley and/or Heritage Valley Beaver Hospital liable, so once we get the verdict slip to look at again, we can look at that language because that's where it's pertinent.

MS. KOCZAN: Your Honor, with regard to Dr. Jones, it should be Heritage Valley Pediatrics rather than just Heritage Valley.

THE COURT: Right. I think I was curtailing myself.

MS. KOCZAN: I'm looking at Dr. Kenkel's report, and if you look at the report on page 19, he says value of lost household services in this report. There's no projection of lost household services and he did not give any testimony or

projection at trial, so to the extent that that is included in there in some of that verbiage, that probably needs to be changed.

THE COURT: So if you look at page 25, "In addition to the monetary contributions decedent would have contributed to her family's support, the plaintiffs are also entitled to be awarded a sum that will fairly and adequately compensate her family for the monetary value of the services, society and comfort that she would have given to her family had she lived, including such elements as work around the house, provision of physical comforts and services and provision of society and comfort."

So you are saying, if I hear you right, Ms. Koczan, this should be eliminated?

MS. KOCZAN: That's correct, because there was no testimony about the value of lost household services, that type of thing. There's nothing in the record with regard to that, so anything that deals with that, household services, the value of household services should be eliminated.

THE COURT: Mr. Price?

MR. PRICE: I don't believe -- I agree that Dr. Kenkel took out that provision in his report. However, I don't believe that this is limited solely to the economic report because -- in fact, I disagree with all of that.

That page 25 paragraph talks about past and future of

noneconomic damages, so this is more of the consortium claim. This is what they're allowed to be awarded for the loss of a family member. She is looking at future lost earnings which would be on page 26.

THE COURT: No, I think she is talking about loss of services. You know, dusting around the house, running to the grocery store, feeding Fido.

MS. KOCZAN: That's what I'm talking about.

MR. PRICE: If that's what this paragraph talks about on page 25, the only thing that should be eliminated is the monetary value of the services that she would have given, just the services like the work around the home, because provision of physical comforts and services or the provision of comforts, society, all of that, it's what makes up the consortium claim. I don't have a problem editing it to take out services but not the whole paragraph.

THE COURT: Okay. So it would read, "In addition to the monetary contributions that the decedent would have contributed to her family's support, the plaintiffs are entitled to be awarded a sum that will fairly and adequately compensate her family for the monetary value of" -- I guess it should say "her society and the comfort that she would have given to her family had she lived, including such elements as work around the home, provision of physical comforts and services and provision of society and comfort."

So Ms. Koczan said that we haven't heard anything about her doing work around the house or what that would be projected to be and there's been no numbers attached to it, so maybe it should be further edited "and the comfort she would have given to her family had she lived," period.

MR. PRICE: How about "had she lived, such as provision of society and comfort"?

THE COURT: I guess you could say that. It's kind of redundant.

MS. KOCZAN: I think maybe the easiest way is at the beginning of that line, "compensate her family for the monetary value of the society and comfort that she would have given to her family had she lived," period.

THE COURT: That's what I thought.

MS. KOCZAN: I think that makes most sense.

THE COURT: Because otherwise, you are adding provision of society and comfort a second time. So we'll edit that paragraph a little bit more. You should all now have a copy of the latest rendition that I reviewed for you. Why don't you take a few minutes and go through it and point out to me any other comments or changes that you have?

And, Ms. Starr, where are we on the revised verdict slip?

THE CLERK: I have it. They sent us a PDF so I had to redo it.

THE COURT: The initial complaint has a totally different caption on it, saying United States of America, Primary Health Network-Beaver Falls Primary Care, Valley Medical Facilities, Inc. t/d/b/a Heritage Valley Pediatrics, Valley Medical Facilities, Inc. t/d/b/a Heritage Valley Beaver, Kevin C. Dumpe and Hilary Jones, so this verdict slip is a lot different than your caption in the complaint. Seems to me it's got to parallel the complaint caption.

MR. PRICE: Your Honor, I believe that we entered into some stipulation after the complaint was filed to correct the caption.

MS. KOCZAN: We might have done that, I don't remember, but I know that the original cannot be the correct one because Dr. Dumpe can't be named so that can't be correct, and I think the verdict slip that we have is what it was corrected to, and I can't remember if it was done by stipulation or whatnot, but regardless, what is in the verdict slip United States of America, Valley Medical Facilities, Inc., trading and doing business, et cetera and Hilary Jones M.D. should be the correct caption.

THE COURT: We've retyped this up, and I want you to take a look at it again, because, prior to our discussion about Hilary Jones and Heritage Valley Pediatrics, what I thought would make sense is you would include them as one defendant, defendant Hilary Jones and defendant et cetera, but

we also talked about possibly dropping a footnote given the stipulation that Hilary Jones is an employee of Valley Medical Facilities, and hence, if she is liable, so are they.

Do you have extra copies of this, Ms. Starr, that you can give to these attorneys?

MS. KOCZAN: Your Honor, she just gave us a copy.

THE COURT: No. No. This is the verdict slip.

MS. KOCZAN: I have my verdict slip.

THE COURT: This has been changed a little bit, and Mr. Galovich, as a representative of the clerk's office, still thinks it's awkward.

MS. KOCZAN: The verdict slip is awkward?

THE COURT: Yes.

Just so the record is clear, final jury instructions, discussion draft number six dated 9-4-19, Ms. Starr is -- I think I said Court Exhibit A or 1, and the proposed verdict slip that you have in front of you is now Court Exhibit B and you need to mark those as exhibits for this proceeding. The attorneys are now reviewing this latest draft of the instructions for their additional comments.

MS. KOCZAN: Your Honor, may I respond on the verdict slip? I think it would be simpler to say defendant Hilary Jones and Heritage Valley Pediatrics period not all the rest of defendant valley trading and doing business as Heritage Valley. I think that's too much. Just Dr. Jones and Heritage

Valley Pediatrics.

THE COURT: What do you think about that, Mr. Price?

MR. PRICE: I like your idea about dropping a footnote just to say that Heritage Valley Pediatrics is Dr. Jones' employer, but if you don't want to, I would rather just have Dr. Hilary Jones, because the verdict is going to be molded.

MS. KOCZAN: That was my original comment to you. I just think it should say Hilary Jones and, Your Honor, given the stipulation, you mold it, I think that's the simplest. Otherwise, we're going to start confusing the jury.

THE COURT: What if the jury comes back with a question and wonders why is only the U.S., Heritage Valley Hospital and Dr. Jones on this slip and not the pediatric group?

MS. KOCZAN: I think Your Honor could tell them that the reason why it is is that, you know, the parties have agreed that Heritage Valley Pediatrics is her employer and if she is found liable, they are found liable period. I think that's pretty simple.

THE COURT: I agree, but I also think it might just be helpful to have it right there on the verdict slip with a footnote.

MR. PRICE: I would prefer that, just because if they're going through all these parties on the caption, I

think that they -- they're going to be wondering what happened to this one party and I think it would be clearer if it's noted.

THE COURT: Okay. So, Ms. Starr, why don't you draft up some language? The parties through counsel have agreed that, to the extent that Dr. Hilary Jones is found liable, then her employer Heritage Valley Pediatrics is likewise liable. We'll just type that up and we'll stick that there and you can ponder that a little bit more, but Mr. Galovich's concern is more related to the second page where he doesn't understand the instructions vis-a-vis the percentage of causal negligence.

We're going to have to take out defendant Heritage Valley Pediatrics on the second page too if we're going to do the footnote. Go ahead, Ms. Koczan.

MS. KOCZAN: Perhaps it may be easier or a way to say it, "If you found that one or more of the defendants was negligent, what percentage of negligence do you attribute to each," and then just list defendant United States, Heritage Valley, Hilary Jones.

THE COURT: I think that's simpler. What do you think, Mr. Price?

MR. PRICE: Can you explain that again?

MS. KOCZAN: Sure. I think what I said was maybe change it to read, "If you found that one or more of the

defendants was negligent, what percentage of liability do you attribute to each, United States, Heritage Valley, Dr. Hilary Jones."

MR. PRICE: That would seem to be a little bit clearer. The only caveat that, whenever you say -- I mean, you continue to use the word factual cause and causal negligence. You just said liable. I think you are right. That would probably be easier.

THE COURT: So we could rewrite question 3 then to that language, so Ms. Starr, can you also type that up? Do you have that retyped?

THE CLERK: Yes.

THE COURT: Print it out so I can go through it while the attorneys are going through the draft instructions.

MR. PRICE: Your Honor?

THE COURT: Yes, sir.

MR. PRICE: In reviewing the jury instructions, you referred to the hospital defendant as defendant Heritage Valley Beaver Hospital, and I was just wondering shouldn't the verdict slip refer to it the same way?

THE COURT: We should probably do that because that's how we have it here. Here on the verdict slip we have defendant Heritage Valley Hospital period. The caption says Heritage Valley Beaver.

MR. PRICE: Right.

THE COURT: So whatever your preference is, if you think it should be all the way through Heritage Valley Beaver instead of hospital, we can do that.

MR. PRICE: It's just in the jury instructions, you refer to it as Heritage Valley Beaver Hospital, and I think if you can put that on the verdict slip.

THE COURT: That was easy enough. So you have an extraneous "and" at the top of the page and you need a "the" on page 2 before verdict form. So once you clean that up, we're going to mark that Court Exhibit C and provide copies to the attorneys so they can look at it again.

MS. KOCZAN: You just added Beaver to number one, Heritage Valley Beaver Hospital.

You need them in both places there.

THE CLERK: Three places.

THE COURT: One Beaver is not enough.

MS. KOCZAN: Your Honor, looking at this more carefully in number 3, it just says negligent, but the first two things -- the first one is were they negligent, was there factual cause. I think there might be some confusion there, so maybe we need to add just a little bit more to No. 3.

"If you find that one or more of the defendants was negligent and that defendant's negligence was a factual cause, what percent of liability do you attribute to each?" That way, it's completely clear. Otherwise, if they answer

question No. 1, they may think they have to 3, and maybe they didn't find factual cause, so I think we probably need just to add that language.

THE COURT: I agree. I think that does make it more complete and more in line with the other questions that are already there, so once again, Ms. Starr, you see what it is to be a law clerk in chambers rather than rotating.

MR. PRICE: Rather than "If you find," how about "If you found that one or more of the defendants is negligent."

THE COURT: Yeah, because they would have already done that.

MS. KOCZAN: "And their negligence was a factual cause, what percentage of liability do you attribute to each?"

MR. PRICE: Except the only thing, liability, I would change to be what percentage of causal negligence because that's what the construction says. It doesn't say percentage of liability.

THE COURT: I think we used shorthand liability but I think you are right. It should be consistent with the terms of our -- they are not going to be instructed on liability. They are being instructed on negligence. So while Ms. Starr does that, back to discussion draft number six. Any other changes that we need to address outside of the issues relating to the damages on page -- I think it's still 25?

MR. PRICE: The only thing, I know Your Honor likes

to be very specific in its language. On page 7, you had mentioned the issue of timelines, and it's not in the first sentence.

THE COURT: Right. I saw that, so I already added that because there were timelines that you all used as PowerPoints, and I was looking, it's kind of wordy, chart summaries, timelines or lists, and then I could say "these items" instead of repeating all that. "These items have not been received in evidence and were shown to you only to explain or illustrate the contents of documents," blah-blah-blah. "These items have not been received were shown to you."

We kept calling them demonstrative exhibits, so why don't we say that, because that's what they heard me say, so "These demonstrative exhibits have not been received in evidence and were shown to you only to explain or illustrate the content of documents, testimony, other evidence in this case. As such, they are not proof of any facts."

I think that reads a little bit better and is not so ponderous, so we'll make those edits. Let me find that damages section here. On page 25, we're going to just end at line 13, "her family had she lived," and not include "including such elements as work around the home," et cetera.

Any other comments? What we'll do, because I know we're kind of moving things along pretty quickly, we'll make

these additional edits and send them to you by e-mail and you'll have another chance to read them tonight, and we'll look at them one more time tomorrow at 8:30. If there are any other additions or changes, we can make them. Generally I try to have the instructions done so that when the jurors go out, they have their little notebooks, they have their binders, they have anything else loose that came in, like those pictures of yours, and then they all take out their own set of instructions, but if Ms. Starr or Mr. Galovich has to run back afterwards and hand them the instructions, I don't think it will be a big deal. We have had to do that on occasion, because in fairness, you are allowed to come back up to sidebar and tell me if there's anything else you want to talk about in terms of instructions before they're charged.

The feedback I get is the jurors all love having hard copy of the instructions when they go back there to deliberate. They really like that.

Sometimes I even give them a hard copy of the preliminary if there's a lot of stipulations of fact so that they have all those stipulations written down. Ms. Starr, have you typed up the verdict slip again?

THE CLERK: Yes.

MR. PRICE: Your Honor, on a procedural issue, I've forgotten, is the closing argument order any different in federal court?

THE COURT: No, except in criminal cases, government always gets the last bite at the apple.

MR. PRICE: So it will be Ms. Koczan and Mike.

THE COURT: And Mr. Colville, unless he wants to waive his argument. He could send me a brief, but I think he's going to close.

MR. COLVILLE: I'll be brief.

THE COURT: You can be as long as you want. That's up to you. What do you all anticipate in terms of closings? About 45 minutes each?

MR. PRICE: Yes.

MS. KOCZAN: Yes.

THE COURT: Let me read this one more time. We are up to Court Exhibit D, right? It's the latest version of the verdict slip. Okay. So, Ms. Starr, you want to print that out so they can all take a look at that one?

The other thing I usually do, once the case has concluded, is I usually have counsel meet with Mr. Galovich so he can make sure that he has a listing of all of your exhibits and that there's no discrepancies. I know much of this case is joint, but you know, out of an abundance of caution, he can be called out here once I've left where you would just meet off the record with him and make sure that his list matches what you all want to go back to the jury.

MR. PRICE: Okay. I did provide the copy of the

Dr. Ringer and Dr. Boyd PowerPoints for my case. I'll leave it up here.

THE COURT: Thank you. Counsel for the defendants have that?

MR. PRICE: Yes.

THE COURT: So, Ms. Starr, here's the latest edits here and this will become discussion draft 7 and become another court exhibit tomorrow morning if we have to revise it some more. Any other comments vis-a-vis the instructions?

MR. PRICE: No, Your Honor.

THE COURT: So Nicole will make those edits we just talked about vis-a-vis the timelines, et cetera. She'll also make the edit vis-a-vis the damages. We'll send that back out on e-mail so everybody has another chance to look at it overnight or later this afternoon, and maybe, Ms. Starr, you can screen mail Mr. Galovich so he can appear and talk to the folks about exhibits and I think he needs to record those Ringer exhibits. I don't know that he's done that.

MR. PRICE: Right.

THE COURT: Anything else for the record at this point? Okay. So he'll just do a staff note that he met with you to go over the exhibits just to make sure that you know what he has on the official court docket matches what you believe has all been entered. Shouldn't take all that long.

You all did get a copy of the latest version of the

verdict slip, Court Exhibit D. Any other changes to it?

MR. PRICE: Looks good to me.

MS. KOCZAN: I don't see any others.

THE COURT: Okay. Mr. Colville is taking a pass.

MR. COLVILLE: I looked at it, Your Honor. It's fine.

THE COURT: I know you looked at it. Mr. Galovich, first off, Mr. Price has some Ringer demonstratives he failed to give you that need to be logged in, and then out of an abundance of caution, maybe you should just double-check exhibits with them.

THE CLERK: It's very straightforward. It was the only exhibits other than the demos were the joint exhibits.

THE COURT: Well, there were those original pictures.

THE CLERK: They were in the binder, judge. I do have those.

THE COURT: I think the idea was that not only are they going to get them in the binder, but they are going to actually get those pictures.

THE CLERK: Indeed. They are right here. I have them in the binder and I have the small versions right here, judge.

THE COURT: I'm presuming you are going to use PowerPoints and the like, right? And the way I normally do things is I give people an opportunity to set up in between in

case you are doing something different, you know, speaking from the podium or not, and also I usually let the jurors stand up and stretch or something so that they concentrate on each of the closings.

This has been an attentive group, I'm sure you've noticed. Some of them have been, in my words, copious note takers, and a few times, I think you struck an emotional chord with various of the jurors and, you know, how they are ultimately going to react to this case is anyone's guess, but, you know, at times, there were a lot of tears in this courtroom.

MS. KOCZAN: Mainly from the witness stand.

THE COURT: Well, no, also from some of the jurors, and we had tears from the witnesses. We had some tears from some of the jurors at different times.

MR. PRICE: I gave you Dr. Ringer and Dr. Boyd's PowerPoints.

THE COURT: The ones that he used with those two witnesses, John.

THE CLERK: I'll mark these on here as demos for each of those doctors, because I've been marking down the days that -- regarding the cross-reference where they testified and I made a reference on here about those original photos you just referenced as follows: Original photos of Joint Exhibits 29 through 34 placed in binder for jury deliberations per

direction of the court on August 28, '19."

THE COURT: Thank you.

MS. KOCZAN: Your Honor, Mr. Colville just pointed out under the Wrongful Death Act in here, there's future noneconomic loss in a lump sum, and it's the same as in the wrongful death. I'm not sure that it should be in both.

THE COURT: I don't think we added that language. I think that came from you attorneys.

MS. KOCZAN: If you look at No. 4, the Wrongful Death Act and then it's the same under the survival.

MR. PRICE: Yes.

MS. KOCZAN: Let me just look at the instructions.

THE COURT: That's what I'm doing myself. It seems to me, if you look under The Survival Act, you would only be looking at future loss of earnings in a lump sum and not the next two items. Am I right on that? When I look at the instructions, that seems to be the way it should read, but as I said, this verdict slip, we got from you all.

MS. KOCZAN: It's not the same for both of them and you know, under the instructions, it's wrongful death, it's the past loss contributions, past and future noneconomic damages, and under survival, it's future loss of earnings and that's it.

MR. PRICE: Your Honor, that might be correct. Just for correction of the jury instructions, on page 24 at line

21, it's entitled "Past Loss Contributions" and I think it should be "Future Loss of Contributions."

THE COURT: Let's see. 24, as you have seen -- where is this again, Mr. Price? Page 24 line 21?

MR. PRICE: Yes, if you take a look at the verdict slip, it says they are -- the damages would cover a future loss of contributions, because --

THE COURT: You are right. Under the Wrongful Death Act, it should say future loss contributions.

MR. PRICE: Right, because she didn't really have any -- I mean, there is no past loss contributions.

THE COURT: Right.

MR. PRICE: My only concern is, and I have to take a look at it tonight, what The Survival Act damages are.

MS. KOCZAN: I'm looking at that right now. I pulled it up on my handy-dandy computer here. Make sure I have the right thing.

THE COURT: Ms. Starr, on this version, it's one of these italicized things that says Past Loss Contributions needs to be made "Future Loss Contributions" under the sentence that begins "Under The Wrongful Death Act."

THE CLERK: I have it.

THE COURT: This is what we'll do, because I need about five minutes to get where I'm going, so we're going to go off the record at this point in time. Ms. Starr will make

these edits as we've talked about to this point, and then she'll e-mail it to all of you unless you want to sit here and work with her line by line. It's a little cumbersome, and in terms of the confusion about the verdict slip, you know, we can also go back in time and pull up other verdict slips that we have had involving wrongful death and survival, but what we were playing off is what you had given us as a joint verdict slip.

MS. KOCZAN: I have a document in my office that identifies all of it, so I'll look at that whenever I go back.

THE COURT: If you could share that with Mr. Price and go back and forth maybe with copy to Mr. Colville, that will speed things up tomorrow. And we can all go on the record at 8:30. I should be here no later than 8:15, I think, tomorrow. Maybe sooner.

As far as your clients go tomorrow, they don't have to be here at 8:30, but they should be here by 9:00 because those jurors will be ready to go. I think they are chomping at the bits to get this case.

MS. KOCZAN: I'm sure they are. It's been a long two weeks for them.

THE COURT: A lot to take in. Eight experts is a lot for anybody.

(At 2:41 p.m., the proceedings were adjourned.)

C E R T I F I C A T E

I, BARBARA METZ LEO, RMR, CRR, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled case.

\s\ Barbara Metz Leo 09/25/2019
BARBARA METZ LEO, RMR, CRR Date of Certification
Official Court Reporter

I N D E X